DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B, WING R 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY {F 000} INITIAL COMMENTS {F 000} F 221 A revisit was completed at East Tennessee Health Care on March 12, 2012, following 483.13(a) Right To Be Free From acceptance of an Allegation of Compliance to Physical Restraints remove the Immediate Jeopardy for F221, F272, F280, F323, F490, F501, and F 520. The revisit SS=E revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy but noncompliance continues at F221 "E" level, Requirements: F280 "E" level, F323 "E" level, F490 "E" level, F501 "E" level, and F520 "E" level, as evidenced The resident has the right to be free by the findings. from any physical restraints imposed Other deficiencies previously cited and not for purposes of discipline or addressed on the Allegation of Compliance convenience, and not required to remain outstanding. The facility is required to treat the resident's medical submit a plan of correction for all outstanding deficiencies including the Immediate Jeopardy symptoms. deficiencies lowered in severity and scope. {F 221} | 483.13(a) RIGHT TO BE FREE FROM Corrective Action Plan: {F 221} SS=E PHYSICAL RESTRAINTS 1. As of 3/5/12, the facility is The resident has the right to be free from any providing a safe environment physical restraints imposed for purposes of discipline or convenience, and not required to through the comprehensive treat the resident's medical symptoms. assessment of each resident to meet

residents (#41, #60, #18, #83, #55, #57) of forty LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This REQUIREMENT is not met as evidenced

Based on Guidance for Industry and FDA (Food

and Drug Administration March 2006) medical record review, facility policy review, observation,

and interview, the facility failed to assess side

not pose a risk for entrapment, and failed to reduce or eliminate side rail restraints for six

rails as a restraint, failed to ensure siderails did

TITLE

the resident's needs and maintaining their optimal physical, mental and

psychosocial well being. The

nursing administration staff

Coordinator, and MDS

Coordinator) conducted

(Director of Nursing, Staffing

assessments (assessments-not

limited to: Side Rail Assessment

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SURPLIED/OLD

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER;	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		445457	B. WING		-	R	
NAME OF PROVIDER OR SUPPLIER		44545/	is. Wilde		03/	12/2012	
	ENNESSEE HEALTH			TREET ADDRESS, CITY, STATE, ZIF 465 ISBILL RD MADISONVILLE, TN 37354	CODE	12/20 /2	
PREFIX	(COOL DELICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPL DAT	
th re	conducted on March corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was accreced review, review observation, and intended and side rail assessment of the conducted, and evident was accorded to the compliance obtained to reduce the compliance. The facility provided evidence obtained to reduce the compliance.	d a Credible Allegation of the 5, 2012. A revisit in 12, 2012, revealed the inplemented on March 5, immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). d: dible Allegation of complished through medical of facility policy, erview with the nurses, and administrative staff. The ence fall risk assessments ments were completed for all yal of side rails when acceptable plan of the ence of the enceptable plan	{F 221}	and Informed Con-	at uation for the achment B), ment ical (attachment ssment leted with the are ident's tifler as that, 57, 60, the use of a for current terventions. The area icated a risk tresident ctors from it was that a the rails due ontinence, is bed.		
OMS-2567(02	2-99) Previous Versions Obsc			communicated changes made	staff de to the		
	- Sido Sido	Event ID:9D8D12	F'#'	D: TN6201			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-0	
	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE COMPI	ETED
NAME OF PROVIDER OR SUPPLIER	445457	B. WING			R
EAST TENNESSEE HEALTH ((X4) ID SUMMARY STA PREFIX (EACH DESICIENCE	TEMENT OF DEFICIENCIES	ID	REET ADDRESS, CITY, STATE, ZIP COD 465 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORF	E	12/2012
	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)		COMPLET DATE
conducted on March corrective actions in 2012, removed the J Non-compliance for citation (potential for The findings included Validation of the Cred Compliance was according record review, review observation, and internursing assistants, ar facility provided evide and side rail assessming residents, with removal indicated, and evident were obtained to reduct risk. The facility provided compliance. The facility will remain level until it provides ar correction to include compute the deficient pratter.	a Credible Allegation of ch 5, 2012. A revisit 12, 2012, revealed the aplemented on March 5, mmediate Jeopardy. F-221 continues at a "E" level more than minimal harm). d: dible Allegation of complished through medical of facility policy, rview with the nurses, and administrative staff. The nace fall risk assessments ents were completed for all all of side rails when see bed zone measurements are or eliminate entrapment ded evidence of in-service in audits to ensure	s c in w A	resident's -I- c	one mat) he Nurse isheet and on 2/17/12 hed by rector of resident's a sensor chair. w bed rom the sident's 4/12 by to ons: ant ht of as ons up offer dry blan hat	

	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/O		A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE S	SURVEY
AME OF	PROVIDER OR SUPPLIER	445457 B. WING			03/5	R
EAST T	ENNESSEE HEALTH		- 1	REET ADDRESS, CITY, STATE, ZIP COI 465 ISBILL RD MADISONVILLE, TN 37354	DE US/	2/2012
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLET
f f a a ring for a record the rec	conducted on March corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was accrecord review, review observation, and intenursing assistants, a facility provided evidend side rail assessmesidents, with remover obtained to reduisk. The facility provider all staff and randorompliance, the facility will remain vel until it provides a prrection to include consure the deficient pre facility's correction to recompliance.	d a Credible Allegation of the 5, 2012. A revisit in 12, 2012, revealed the inplemented on March 5, immediate Jeopardy. F-221 continues at a "E" level more than minimal harm). d: dible Allegation of complished through medical of facility policy, erview with the nurses, and administrative staff. The ence fall risk assessments ments were completed for all real of side rails when the process of the ence of in-service in audits to ensure out of compliance at a "E" in acceptable plan of continued monitoring to actice does not recur and measure could be die by the Quality Assurance	ti u si	from 2/24/15	atus. The ted on ursing ger uiring The constant on of uced Our ff gain anding or ssment the ff de at at a second constant on the constant of t	

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE	O. 0938- SURVEY LETED
AME OF 6	BROWNER AT ALL	445457	B, WING			R
	PROVIDER OR SUPPLIER		. 9	TREET ADDRESS, CITY, STATE, ZIP COR 465 ISBILL RD MADISONVILLE, TN 37354	03/ DE	12/2012
PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	111A	COMPLE DATE
find a review of the review of	three residents reviewed the facility provided Compliance on March corrective actions in 2012, removed the I Non-compliance for citation (potential for The findings included Validation of the Crecompliance was accorded to review, reviewed beservation, and interesting assistants, and acility provided evidents and side rail assessment of the facility provided evidents. The facility provided evidents are obtained to redust. The facility provides are obtained to redust. The facility will remain the facility will remain the facility will remain the facility will remain the deficient provides are facility's correction to include consure the deficient provides are facility's correction to facility and the	a Credible Allegation of ch 5, 2012. A revisit of 12, 2012, revealed the inplemented on March 5, immediate Jeopardy. F-221 continues at a "E" level of more than minimal harm). d: dible Allegation of complished through medical of facility policy, rview with the nurses, and administrative staff. The ence fall risk assessments ments were completed for all all of side rails when the process of the ence of in-service of audits to ensure out of compliance at a "E" in acceptable plan of continued monitoring to actice does not recur and measure could be did by the Quality Assurance	{F 221	nor MDC 1/ C	ded with ions, or e rails the changed s (prior e) on ts for ed by on e vas fing ne use n from after or for ffing f the nat	

ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) M(t)	TIDI E OCUE	OMB NO. 0938-
	- COMMEGNON	IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SURVEY COMPLETED
/A15 05 -		445457	B. WING		R
NAME OF PROVIDER OR SUPPLIER					03/12/2012
EAST TE	ENNESSEE HEALTH		1 1	REET ADDRESS, CITY, STATE, ZIP CODE 466 ISBILL RD MADISONVILLE, TN 37354	
PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		
TAG		SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(//)
F 221}	pd Holli ha	ge 1	(F 004)	zone measurements were o	latai 1
	three residents revi	ewed.	{F 221}	by the Maintenance Directe	blained
	The facility provided	a Credible Allegation of		2/6/12. A Pre-Restraint	or on
1				Assessment was annual	
1				Assessment was completed 2/21/12 by the Staffing	on
	2012, removed the l	plemented on March 5,		Coordinator that indicated s	
citatio				tails being used	side
	oradion (potential for	more than minimal harm).		rails being used as a restrain assisting the resident with	nt and
	The findings include	d:	1	position changes A F	
1	Validation of the O			position changes. An Evalu	ation
Validation of the Credible Allega			for the use of Side Rails was	3	
1	Compliance was accomplished through medical record review, review of facility policy,	1	completed on 2/23/12 by the	:	
			ĺ	Staffing Coordinator with a	
f	acility provided evide	nd administrative staff. The		reduction of side rails from !	∕₂ side
l a	and side rail assessm	nents were completed for all		rails to ¼ side rail in combin	ation
ir	idicated and eviden	ar of side rails when		with a low bed. The bed/side	rails
W	vere obtained to redu	ce or eliminate entrapment	- 1	were changed out by the	
fo	or all staff and roads	ded evidence of in-service		Maintenance Director;	
c	or all staff and randor ompliance.	n audits to ensure		measurements were obtained	on
Т	he facility			2/23/12. The care plan was	
le	vel until it provides a prection to include or	out of compliance at a "E"		audited by the Nursing	
00	prection to include a	acceptable plan of	1	Administration Staff to ensure	e
the	sure the deficient pro	actice does not recur and		that the plan of care had been	
the facility's corrective m reviewed and evaluated Committee.	measure could be		updated to reflect the resident	's	
	d by the Quality Assurance		current status on 2/26/12.	1	
				Resident was transferred to	
				hospital on 2/26/12. The Inter	inı
				MDS Coordinator completed a	. 4
				Discharge Assessment on 2/20	/12
\$-2587(02	99) Previous Versions Obsol	nte		which reflected the use of side	
		Event ID: 9D8D12	Facility ID		

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	\neg			OMB NO.	0938-0
DENTIFICATION NUMBER:		Zec Crester	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445457	B. WI	NG		F	₹
NAME OF F	PROVIDER OR SUPPLIER			DTD	EET ADDRESS A TOTAL	03/12	2/2012
	ENNESSEE HEALTH			46	EET ADDRESS, CITY, STATE, ZIP CODE 5 ISBILL RD ADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	LACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DAH	(XS COMPILE DAT
	three residents rev The facility provide Compliance on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was ac record review, revie observation, and interpretation nursing assistants, a facility provided evid and side rail assess residents, with remo indicated, and evide were obtained to red risk. The facility provider for all staff and rando compliance. The facility will remail evel until it provides correction to include ensure the deficient p the facility's correction the facility's correction	d a Credible Allegation of rch 5, 2012. A revisit th 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. Immediate Allegation of complished through medical work of facility policy, erview with the nurses, and administrative staff. The lence fall risk assessments ments were completed for all val of side ralls when note bed zone measurements luce or eliminate entrapment wided evidence of in-service or audits to ensure. In out of compliance at a "E" an acceptable plan of continued monitoring to practice does not recur and a measure could be led by the Quality Assurance.	{F 2	in the state of th	rails as a restraint (as ½ rails used until 2/23/12 during the day look back period). The resident was reassessed upon return to the facility on 3/12/1 the admitting Charge Nurse we completed an Evaluation for the use of Side Rails and a Fall Rindssessment with the recommendation for no side raindicated at this time. The MT Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse of an ongoing base and as needed with any new orders, interventions, or changes. (c) Resident #18 The side rails that were in place during the survey were immediately change of full anti-entrapment rails on 1/6/12 by the Maintenance director after receiving a	2 by who he sk wils on	

AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	IMBER: (X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	URVEY
			A. BUILD		COMPL	
NAME OF F	100100	445457	B. WING		02/4	R
	ROVIDER OR SUPPLIEF		S	TREET ADDRESS, CITY, STATE, ZII	P CODE	2/2012
	NNESSEE HEALTH	5-3		465 ISBILL RD MADISONVILLE, TN 37354	3001,	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID .	PROVIDER'S PLAN OF	CORRECTION	
TAG	TESOLATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEPICIENT	TION SHOULD BE THE APPROPRIATE	COMPLETI DATE
{F 221}		page 1	{F 221	physician's order. I	he	
	three residents re	viewed.	(, 221	measurements for th	ne bed zones	÷
	The facility provide	ed a Credible Allegation of		were obtained by the	e Maintenance	
j	Compliance on W	arch 5 2012 A rouge:		Director on 2/6/12 u	sing a	
	SOLICOTIVE SCHOOLS	rch 12, 2012, revealed the implemented on March 5,		standard tape measu	re with	
	ZO 12, Telliaved in	e Immediate Igonordi.		measurements. The	Staffing	1
	citation (potential	or F-221 continues at a "E" level for more than minimal harm).		Coordinator wrote a	narrative	
				note in the nurses no	tes on 2/6/12	
	The findings include	***		describing the reside	nt with	
5	Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and inserview with the nurses, pursing accidents.	redible Allegation of		limited functional sta	itus using the	
			side rails as a restrair	nt. A Physical		
1			Restraint Assessment	was		
	facility provided ev	and administrative staff. The		updated on 2/6/12 by	the Staffing	
100		SITIANTE WARE A		Coordinator for the us	se of side	
		ioval of side rails when ence bed zone measurements		rails. A Side Rail Ass	sessment	
				and Informed Consent by the family on 2/13/	t was signed	
		ovided evidence of in-service dom audits to ensure		2/20/12 the MDS Coo	12. On	
(compliance.	dom addits to ensure		completed an Evaluati	romator	
j-	The facility will rem	ain out at a		of Side Rails with a re	on for use	
1	evel until it provide:	ain out of compliance at a "E" s an acceptable plan of	1	side rails from full (an	duction in	
			1	entrapment) to ½ rails,	the	
t	he facility's correcti	practice does not recur and ve measure could be		physician was notified	and order	
1000	eviewed and evaluation	ated by the Quality Assurance		was obtained for 1/2 rail	s. The	
	, and the same of			measurements for the b	ed zones	
				were obtained by the M	aintenance	
1				Director on 2/20/12. C	n 2/23/12	
			ļ.	the resident was evaluat	ted again	
4 CMS-2567(02-99) Previous Versions C	Phoelists		for side rail reduction by	y the	
83	versions (posolete Event ID: 9D8D12	Facilit	UID- TNGODA	f continuation sheet P	

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION	(X3) DATE (0. 0938-0: SURVEY ETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING			R
	ENNESSEE HEALTH		, 3	TREET ADDRESS, CITY, STATE, ZIP CO 465 ISBILL RD MADISONVILLE, TN 37354		2/2012
PRÉFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ALIALU	(X5) COMPLETE DATE
T le C e tr	three residents review Compliance on March conducted on March corrective actions in 2012, removed the I Non-compliance for citation (potential for The findings included Validation of the Crecompliance was accord review, review observation, and intenursing assistants, at facility provided evide and side rail assessments and side rail assessments. The facility provided evidents were obtained to reduct the facility will remain compliance. The facility will remain a correction to include a consure the deficient proper facility's correction to include consure the deficient proper facility's correction to include on the facility's correction to include on the facility's correction to include on the facility's correction to include the facility the facility is correction.	a Credible Allegation of ch 5, 2012. A revisit 12, 2012, revealed the aplemented on March 5, mmediate Jeopardy. F-221 continues at a "E" level more than minimal harm). d: dible Allegation of omplished through medical of facility policy, rview with the nurses, and administrative staff. The ence fall risk assessments the bed zone measurements alled of side rails when the bed zone measurement ded evidence of in-service maudits to ensure out of compliance at a "E" in acceptable plan of ontinued monitoring to actice does not recur and measure could be dien by the Quality Assurance	{F 221	C. 00	dent was th mats. Atted on ination of a low bed g a care plan ing ensure been ident's On of bed upper neck d eep room Sowel etermine eed Our eplan	

AND BLANDE COORDENANCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/GLIA	/X2) M	X2) MULTIPLE CONSTRUCTION (X31)		MB NO. 0938-039	
	- John Child	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER		445457	B. WIN	NG	2 <u>11</u> 02.00	R	
	ENNESSEE HEALTH	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 465 ISBILL RD	ODE 03/	12/2012	
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	1	MADISONVILLE, TN 37354	120-0-0		
TAG	REGULATORY OR I.	SC IDENTIFYING INFORMATION)	PREFI	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I OLIGIU A AL	COMPLET DATE	
i v r fi	three residents reviewed three residents reviewed the Non-compliance for citation (potential for compliance for citation (potential for compliance for citation (potential for citation of the Crecompliance was accordance for citation of the Crecompliance was accordance to the facility provided evidents. The facility provides accompliance.	d a Credible Allegation of rich 5, 2012. A revisit h 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). The received from the implemented of complished through medical who facility policy, erview with the nurses, and administrative staff. The ence fall risk assessments were completed for all risk assessments were or eliminate entrapment rided evidence of in-service in audits to ensure	{F 22	wheel chair in another room, with intervention proper footwear (nonsk footwear when resident as allows with physical screen. On 3/15, further intervention was added after breakfast as desired further investigation of 3/13. Fall on 3/17 when rolled from the bed in her bed was in lowest position mats on both sides, no in noted, intervention to admodles to define perimer bed with all above intervention as implemented. Resident's plan is updated per MDS Charge Nurse on an ongo	resident's as for id) replace removes therapy to resident of the resident er sleep, on with jury id pool ter of the entions care and/or ing		
l th	e facility's corrective	ractice does not recur and measure could be ed by the Quality Assurance		bases and as needed with orders, interventions, or of (d) Resident #83 The	any new		
			1	recapitalization and			
				recapitalization orders we	re		
				signed by the physician fo	r 2/2/12		
MS-2567(0)	2-99) Previous Versions Obsc			included an order for the side rails. An assessment	use of		
	Previous Versions Obsc	plate Event ID: 9D8D12		ty ID: TN6201	was		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-14000000000000000000000000000000000000	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445457	A. BUILDING B, WING		R 03/12/2012	
	ROVIDER OR SUPPLIER NNESSEE HEALTH		468	ET ADDRESS, CITY, STATE, ZIP CODE S ISBILL RD ADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORREC	CTION (XS)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DESIGNACY)		
{F 221}	three residents rev The facility provide Compliance on Mar conducted on Mar corrective actions 2012, removed the Non-compliance for citation (potential if The findings include Validation of the C Compliance was a record review, rev observation, and if nursing assistants facility provided ex and side rail assess residents, with ren indicated, and evic were obtained to r risk. The facility p for all staff and ran compliance. The facility will ren level until it provide correction to includensure the deficient the facility's correct the facility'	ed a Credible Allegation of arch 5, 2012. A revisit ch 12, 2012, revealed the implemented on March 5, a Immediate Jeopardy. Or F-221 continues at a "E" level for more than minimal harm). Ided: Credible Allegation of accomplished through medical lew of facility policy, interview with the nurses, and administrative staff. The vidence fall risk assessments assments were completed for all moval of side rails when dence bed zone measurements educe or eliminate entrapment rovided evidence of in-service indom audits to ensure. The provided evidence of in-service indom audits to ensure the continued monitoring to the practice does not recur and citive measure could be uated by the Quality Assurance.	{F 221}	completed on 2/6/12 using Restraint Assessment for to of 1/4 side rails completed MDS Coordinator indication restraint was recommended related to cognitive impair requiring physical assistant unaware of safety issues. 2/20/12 an Evaluation for of Side Rail Assessment was completed by the MDS Coordinator indicating the resident was unaware of side needs, cognitive impairment requiring physical assistant utilizing 1/4 side rails. An Evaluation for the use of Side Rails was completed on 2/2 by the Director of Nursing reduction of side rails from 1/2. The resident's Physical Restraint Assessment was updated on 2/23/12 by the Director of Nursing for the restraint reduction and new received for the use of 1/2 strails. On 2/28/12, an Evaluation the use of Side Rails and Physical Restraint Assessment Assessment Restraint Assessment Restraint Assessment Restraint Rails and Physical Restraint Assessment Rails Rails and Physical Restraint Assessment Rails Rails and Physical Restraint Assessment Rails	the use by the ing a ed rment, nce, and On the use was e afety ent, and nce ew Side /23/12 g for the m 3/4 to al e w orders side pation and	

STATEMENT OF DEFICIENCIES (X1) PR AND PLAN OF CORRECTION IDE		DENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A, BUILDING				₹	
		445457	B. Wil	NG.		03/1	12/2012	
	ROVIDER OR SUPPLIER NNESSEE HEALTH (CARE			TREET ADDRÉSS, CITY, STATE, ZIP CODE 466 ISBILL RD MADISONVILLE, TN 37354			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	(D		PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
{F 221}	(21) Continued From page 1		{F 2	221	was completed by the Dire			
1	three residents rev	reviewed.	,		Nursing indicating the elir			
	The facility provide	d a Credible Allegation of			of ½ rails and placed on lo	w bed		
	Compliance on Ma	rch 5, 2012, A revisit			with mats. The care plan	was	İ	
	conducted on Marc	ch 12, 2012, revealed the			audited by the Nursing			
	corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy.				Administration Staff to ens			
	Non-compliance for	or F-221 continues at a "F" level			that the plan of care had be			
	citation (potential for	or more than minimal harm).			updated to reflect the resid			
4	The findings includ	led.			current status on 2/29/12.	0.0000000000000000000000000000000000000		
		i			plan is current to resident's			
	Validation of the Ci	redible Allegation of			and is updated per MDS ar	ıd/or		
	record review, revi	ccomplished through medical ew of facility policy,			Charge Nurse on an ongoir	ıg		
i	observation, and in	terview with the nurses			bases and as needed with a	ny new		
	nursing assistants, facility provided evi	and administrative staff. The			orders, interventions, or ch			
	residents, with rem	sments were completed for all oval of side rails when			(e) Resident # 55 was assesse	ed using		
	indicated, and evid	ence bed zone meacurements			a Pre-Restraint Assessment (1	ised due		
	Mere obtained to te	Educe or eliminate entrepend			to the use of side rails as restr	aint)		
	for all staff and rand	ovided evidence of in-service dom audits to ensure			was completed on 2/6/12 by t			
	compliance.	dudies to ensure			MDS Coordinator indicating t	hat a		
	The facility will row				restraint (3/4 side rail and geri	chair)		
	react outfill follower	ain out of compliance at a "E" s an acceptable plan of			was recommended due to cog	nition		
	COLLECTION TO IUCITIO	© Continued monitoring to			impaired, physical limitations,	, and		
is.	cristic the deficien	DIactice door not reason			history of falls. The care plan	was		
	reviewed and evalu	ive measure could be ated by the Quality Assurance			audited by the Nursing	100		
	Committee.	ay and equality Assurance			Administration Staff to ensure	that		
					the plan of care had been upda	ted to		
					reflect the resident's current st 2/6/12. No further assessmen	atus on		
					could be completed due to the	ts .		
					resident expiring on 2/16/12.			
FORM CMS-256	7(02-99) Previous Versions	Obcolete			Apriling on 27 (0/12.			
	,	Cosplete Event ID: 9D8D12	200	F-				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE	
			A. BUILDING		COMPL	
		445457	B. WING		02/	R 12/2012
	PROVIDER OR SUPPLIER	CARE		TREET ADDRESS, CITY, STATE, ZIP 465 ISBILL RD MADISONVILLE, TN 37354		12/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
1	three residents revided Compliance on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was accredity provided evice and side rail assess residents, with remoindicated, and evide were obtained to recrisk. The facility provides compliance. The facility will remain level until it provides correction to include ensure the deficient the facility's correction to the facility's correction to include the facility that the facility is correction to include the facility is correction.	d a Credible Allegation of rch 5, 2012. A revisit h 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). deting the allegation of complished through medical w of facility policy, erview with the nurses, and administrative staff. The dence fall risk assessments ments were completed for allegation of side rails when ince bed zone measurements duce or eliminate entrapment vided evidence of in-service om audits to ensure	{F 221	(f) Resident # 57 A tele was received from the rephysician for the use of on 2/10/12. The resider assessed on 2/20/12 usin Evaluation for use of Side the evaluation of side raindicating the use of ½ s the Staffing Coordinator Restraint Assessment was on 2/21/12 by the Direct Nursing that indicated sitused as a restraint. On 2/2 another Evaluation for the Side Rail was completed Staffing Coordinator indicating are in place at this time 2/24/12 the resident's interinclude: the locking of whe prior to transfer, offer rest assist to the bathroom duri and as needed, bed in lower position, a chair sensor pace plan was audited by the Nursing on 3/7/12 and evaluation of 2/20/12. The resident's care was reviewed by the Director Nursing on 3/7/12 and evaluation of 2/20/12 and ev	esident's ½ side rails at was ag the de Rails (for il use) ide rails by A Pre- as completed or of de rails are 24/12 e use of by the cating the cating the is (no side ine). As of rventions eel chair periods, ing rounds est I. The care irsing ure that pdated to t status on e plan	

PRINTED: 03/14/2012 FORM APPROVED

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMP	<u>2. 0938-0:</u> Survey Leten
		445457	B. WING		-	R
	PROVIDER OR SUPPLIER ENNESSEE HEALTH		sı	REET ADDRESS, CITY, STATE, ZIP	CODE 03/	12/2012
(X4) ID PREFIX TAG	REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
i	three residents rev The facility provide Compliance on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was ac record review, revie observation, and intraursing assistants, a facility provided evice and side rail assess residents, with remoindicated, and evide were obtained to record review. The facility will remain compliance. The facility will remain evel until it provides correction to include the facility's corrective the facility	d a Credible Allegation of rch 5, 2012. A revisit h 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). det: edible Allegation of complished through medical w of facility policy, erview with the nurses, and administrative staff. The lence fall risk assessments ments were completed for all val of side rails when noce bed zone measurements luce or eliminate entrapment vided evidence of in-service or audits to ensure in out of compliance at a "E" an acceptable plan of continued monitoring to represent the service of the servic	{F 221}	the intervention for consupervision during toile inappropriate. After reventions or the Director of Nursing investigation of the incidintervention not to leave it was determined that the intervention was implemented a full root cause analysis conducted (the intervention was of 2/24/12 in above). As of 3/22/12, conterventions, the resident the FROG (Falls Reduce program, participates in with ambulation "walk to program", low bed with antiroll back brakes, the wheel chair prior to transerest periods, ask resident on rounds if she would lift or needs assist to the bath during rounds and as need monitoring and intervention continue to prevent falls. Care plan is current and per MDS and/or Charge an ongoing bases and as with any new orders, interventions, or changes interventions.	eting was view of a 3/7/12 by and further dent (with e unattended) he nented before s was ion was nterventions current of remains on ed Our Goal) restorative of dine mats, locking of fer, offer frequently ke anything room led, further ons will Resident's updated Nurse on	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		445457	B. WIN	IG_		03/1	2/2012
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	4 IV	REET ADDRESS, CITY, STATE, ZIP GODE 65 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	OULD BE ROPRIATE	(X5) COMPLETION DATE
	Compliance on Maconducted on Maconducted on Maconducted on Maconducted on Maconducted on Maconducted and side rail assertiation (potential) The findings included and side rail assertiation, and nursing assistants facility provided eand side rail assertiation, with reindicated, and evice were obtained to risk. The facility if or all staff and racompliance. The facility will relevel until it provided ensure the deficient to incluensure the deficient the facility's correction to incluensure the deficient to incluent the deficient to incluent the deficient to inclue the facility's correction to incluent the deficient the d	ed a Credible Allegation of arch 5, 2012. A revisit rch 12, 2012, revealed the implemented on March 5, e Immediate Jeopardy. for F-221 continues at a "E" level for more than minimal harm). ded: Credible Allegation of accomplished through medical view of facility policy, interview with the nurses, and administrative staff. The vidence fall risk assessments resements were completed for all moval of side rails when idence bed zone measurements reduce or eliminate entrapment provided evidence of in-service andom audits to ensure main out of compliance at a "E" des an acceptable plan of ide continued monitoring to ent practice does not recur and ctive measure could be alluated by the Quality Assurance	{F 2	21}	2. (a) The Nursing Administration of Nursing, Coordinator, and Staffing Coordinator, and Staffing Coordinator) reviewed all residents using side rails, assessing and coding the resident's assessment correct Residents using side rails a restraint were identified an planned accordingly. A comprehensive assessment completed; interventions we modified as needed and plathe individuals care plan. The Administration Team (Administration Team (Administration, Director of Nursing, and Assistant Director, MDS Coordinator, Service Supervisor, Activita Director, and/or Medical Director with implementation on 2/28/12 include the utilization of the Evaluation for the use of Service of S	MDS ectly. as a ad care was were aced on The fector of ervisor, s r, Food ty Rail at of to te ide were ide	

TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII 7	TIPLE CONSTRUCTION	OMB NO) <u>. 0938-</u> 0	
	IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	445457	B. WING_		03/	R 2/2012	
EAST TENNESSEE HEALTH C	CARE	4	REET ADDRESS, CITY, STATE, ZIP COD	E	MEUIZ	
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354			
TAG REGULATORY OR LE	YEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)		(X5) COMPLET DATE	
conducted on March corrective actions im 2012, removed the II Non-compliance for citation (potential for The findings included Validation of the Cred Compliance was accorrected review, review observation, and internursing assistants, ar facility provided evide and side rail assessming residents, with removindicated, and evident were obtained to redurisk. The facility provided rail staff and random compliance. The facility will remain level until it provides are correction to include consure the deficient pratter facility's correction to the facility the facility's correction to the facility's correction to the facility the facility's correction to the facility the facility's correction to the facility the fa	a Credible Allegation of ch 5, 2012. A revisit 12, 2012, revealed the plemented on March 5, mmediate Jeopardy. F-221 continues at a "E" level more than minimal harm). dible Allegation of complished through medical of facility policy, view with the nurses, and administrative staff. The nace fall risk assessments lents were completed for all all of side rails when the bed zone measurements are or eliminate entrapment ded evidence of in-service in audits to ensure out of compliance at a "E" in acceptable plan of continued monitoring to actice does not recur and measure could be if by the Quality Assurance		frame (ranging from ¼ to rails). The nursing admin Team (Director of Nursin Staffing, Coordinator and Coordinator) assessed resusing side rails utilizing the Evaluation for the use of Rails on 2/28/12 and 2/29. These tools (Side Rail Assessment and Informed Consent Form, Evaluation use of Side Rails, Pre-Rest Assessment, and the Physic Restraint Assessment) were for the purpose of assessing residents using side rails to determine if side rails were needed and/or could be redunctification of family and/or resident of the use of side rails/restraints, to determine restraint was recommended, to review the resident for poreduction of a restraint. The Restraint Assessment was completed for residents using rails as restraints to assess residents using side rails to determine if side rails were	inistration ag, I MDS idents be Side /12. for the traint cal c used if a and ssible Pre-		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES
STATEMENT OF DEFICIENCIES
(X1) PROVIDERS UPDITIES OF THE PROVIDERS UPDITIES
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		445457		G	R
	ROVIDER OR SUPPLIER NNESSEE HEALTH OF SUMMARY STA	TEMENT OF DESIGNATION	ID.	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF GORRECT	03/12/2012
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	II DE COMPLETION
	three residents revier The facility provided Compliance on March Compliance on March Corrective actions in 2012, removed the Non-compliance for citation (potential for the findings include Validation of the Cre Compliance was accord review, review observation, and intensing assistants, a facility provided evid and side rail assessing residents, with removindicated, and evidents. The facility provided residents are obtained to redirect the facility will remain evel until it provides correction to include the facility's correction to include the facility that the facility is correction to include the facility that the facility that the facility is correction to include the facility that the facility that the facility is correction to include the facility that the facility that the facility is correction to include the facility that the facility that the facility is correction.	a Credible Allegation of ch 5, 2012. A revisit 12, 2012, revealed the aplemented on March 5, ammediate Jeopardy. F-221 continues at a "E" level of more than minimal harm). d: dible Allegation of complished through medical of facility policy, erview with the nurses, and administrative staff. The ence fall risk assessments were completed for all val of side rails when note bed zone measurements under or eliminate entrapment wided evidence of in-service or audits to ensure In out of compliance at a "E" can acceptable plan of continued monitoring to practice does not recur and a measure could be ed by the Quality Assurance	{F 22	recommended as a restraint 2/28/12 by the Nursing Administration Team, with findings documented on the resident's individual assessment Informed Consent Form, Evaluation for the use of Sic Rails, Pre-Restraint Assessment). Through the individual resident assessment and monitoring of side rail uthe facility has been able to reduce the use of side rails we current total of 4 residents (mails). Side rails that were reduced or removed by the Maintenance Director based the resident's individual assessment results by nurse administration beginning on 2/6/12 through 2/29/12. The Maintenance Director and the Maintenance Assistant obtain measurements of all remainir side rails using a standard tap measure. Measurements were obtained with the bed in a flat	ment and de nent t int ise, vith a io full on
		Solete Event ID: 9D8D12	Fac	clifty ID: TN6201 If continue	ation sheet Page 2 of 38

PRINTED: 03/14/2012 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	9	445457	B. WING_		R		
EAST TE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354				
(X4) ID PREFIX TAG	(GACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OUD BE COMPLETION		
	The facility provide Compliance on Marconducted on Marcorrective actions i 2012, removed the Non-compliance for citation (potential for The findings included Validation of the Crompliance was accord review, review, review, review, review, facility provided eview and side rail assess residents, with remaindicated, and evidente were obtained to review. The facility provides compliance. The facility will remain the facility's correction to include the facility's correction the facility's correction to marcorrection to include the facility's correction to marcorrection to	d a Credible Allegation of arch 5, 2012. A revisit ch 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). The decinate of the complished through medical ew of facility policy, terview with the nurses, and administrative staff. The dence fall risk assessments sments were completed for all eval of side rails when ence bed zone measurements duce or eliminate entrapment evided evidence of in-service from audits to ensure. The dence fall risk assessments are the service of the service	(F 221)	met the FDA recommendal referenced in the FDA Hose Bed System Dimensional at Assessment Guidance to Rentrapment. Any side rail measured outside the FDA recommendations were replaced as needed with anti-entrapherails, shorter side rails (1/4, and 3/4) or eliminated as needed on the resident's indicassessments and/or for non (c) The resident's physical family member and/or resident measured aware of side reassessments/restraint finding 2/6/12, obtaining new order needed by the Nursing Administration Team, the fand/or resident provided veconsent for the use of side rail/restraint as indicated. Ongoing communication we discussed with families/resident regarding the use of side rail restraint upon admission and assessment findings change the Admission Coordinator,	tions as spital and educe that slaced ment y/2, eeded ividual -use. ian, dents ail mgs on ers as family erbal ill be idents its and d/or as by		
		Event ID: 9D8D12	Facility	y ID: TN6201 If contin	nuation sheet Page 2 of 38		

04/02/2012 08:11

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 221} Continued From page 1 Charge Nurse or Nurse {F 221} three residents reviewed. Administration Team. The facility provided a Credible Allegation of 3.(a) The nursing administration Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the staff (Director of Nursing, corrective actions implemented on March 5, Assistant Director of Nursing, and 2012, removed the Immediate Jeopardy. MDS Coordinator) communicated Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). changes to the resident's status such as bed changes, modification The findings included: of side rails, or modification to Validation of the Credible Allegation of restraint usage to the direct care Compliance was accomplished through medical givers (list not all inclusive: record review, review of facility policy, observation, and interview with the nurses, CNA's, licensed nurses, and nursing assistants, and administrative staff. The therapist) on the Nurse Aide facility provided evidence fall risk assessments and side rail assessments were completed for all Communication Worksheet, Care residents, with removal of side rails when Plans, and/or the 24 hour report indicated, and evidence bed zone measurements book as of 2/28/12. The Assistant were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service Director of Nursing or the MDS for all staff and random audits to ensure Coordinator will post an updated compliance. list for residents with side rails in The facility will remain out of compliance at a "E" the front of the CNA assignment level until it provides an acceptable plan of book as changes are made to the correction to include continued monitoring to ensure the deficient practice does not recur and resident's current side rail status the facility's corrective measure could be beginning 2/29/12. The MDS reviewed and evaluated by the Quality Assurance Coordinator, the backup MDS Coordinator, and/or charge nurse will update the care plan, and the Nurse Aide Communication Sheet to reflect changes as new orders or events occur, communicating FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility in the 24 hour report.

it continuation sheet Page 2 of 38

NAME OF PROVIDES OR SUPPLIER EAST TENNESSEE HEALTH CARE SUMMAY STATEMENT OF DEFICIENCIES (AND ADDISONVILLE, TN 37344 AND SIGNALLE, TN 37354 SUMMAY STATEMENT OF DEFICIENCIES (AND ADDISONVILLE, TN 37354 AND SUMMAY STATEMENT OF DEFICIENCIES (AND ADDISONVILLE, TN 37354 AND SUMMAY STATEMENT OF DEFICIENCIES (AND ADDISONVILLE, TN 37354 AND SUMMAY STATEMENT OF DEFICIENCIES (AND ADDISONVILLE, TN 37354 AND SUMMAY STATEMENT OF DEFICIENCY (AND ADDISONVILLE, TN 37354 (F 221) Continued From page 1 (Three residents reviewed. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 5, 2012, removed the Immediate Jeepardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails wiren indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure compliance of in-service for all staff and random audits to ensure compliance. The facility will remain out of compliance at a "E" level until it provides evidence for all reviewed and evaluated by the Qualify Assurance The facility will remain out of compliance at a "E" level until it provides evidence	S LA TEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(XS) DATE SURVEY COMPLETED	
EAST TENNESSEE HEALTH CARE ADDISONVILLE, TN 37354 PROVIDERS PLAN OF CORRECTION MUST as PRECEDED BY PULL PREFIX PAGE PREFIX PAGE PREVIOUR SECTION MUST as PRECEDED BY PULL PRESIDENCY OR LISC IDENTIFYING INFORMATION) PREFIX TAG			445457			TOTAL POOL
(F 221) Continued From page 1 three residents reviewed. The facility provided a Credible Allegation of Compliance on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeoparty, Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-aervice for all staff and random audits to ensure compliance. The facility provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. Chi The Maintenance Director or Assistant will bring the Side Rail Log to the morning Quality assurance to side rail measurements. The Side Rail log will be used to record the findings of side rail asaded, quarterly, and/or as needed). (c) Measurements obtained by the Maintenance Director, Assistant, or charge nurse, as recommended in the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. The Side Rail Log (attachment H) process is part of the new Side Rail Policy initiated Carles of the new Side Rail Policy initiated by the Administrator, Maintenance Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be	EAST TE	NNESSEE HEALTH (SUMMARY ST) (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SUIT	ID	465 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRE	
three residents reviewed. The facility provided a Credible Allegation of Compliance on March 15, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the scall log will be used to second the findings of side rail measurements. The Side Rail log will be used to record the findings of side rail measurements. The Side Rail log will be used to record the findings of side rail measurements. The Side Rail log will be used to record the findings of side rail wasurements. The Side Rail log will be used to record the findings of side rail measurements. The Side Rail log will be used to record the findings of side rail measurements. The Side Rail log will be used to record the findings of side rail wasurements. The Side Rail log will be used to record the findings of side rail wasurements. The Side Rail log will be used to record the findings of side rail wasurements. The Side Rail log wall measurement					CROSS-REFERENCED TO THE APP	ROPRIATE DATE
Event ID:9D8D12 Faulth-ID Three		The facility provide Compliance on Marcorrective actions i 2012, removed the Non-compliance for citation (potential for The findings including Validation of the Cr. Compliance was acrecord review, review observation, and in nursing assistants, facility provided eviand side rail assess residents, with remindicated, and evide were obtained to rerisk. The facility profor all staff and rand compliance. The facility will remain the facility's correction to include ensure the deficient the facility's correctireviewed and evaluation committee.	d a Credible Allegation of rch 5, 2012. A revisit ch 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). ed: redible Allegation of complished through medical ew of facility policy, terview with the nurses, and administrative staff. The dence fall risk assessments sments were completed for all oval of side rails when ence bed zone measurements duce or eliminate entrapment ovided evidence of in-service dom audits to ensure ain out of compliance at a "E" is an acceptable plan of the continued monitoring to the practice does not recur and the ve measure could be atted by the Quality Assurance	{F 221	Assistant will bring the Sid Log to the morning Quality Assurance meeting to discussifindings related to side rail measurements. The Side Rawill be used to record the foof side rail measurements (side rail is added, quarterly and/or as needed). (c) Measurements obtained Maintenance Director, Assor charge nurse, as recommended in the Food and Drug Administration (FDA) Hose Bed System Dimensional at Assessment Guidance to Resultangement dated March 192006. The Side Rail Log (attachment H) process is put the new Side Rail Policy in 2/28/12. All staff was in see by the Administrator, Maintenance Director and/or Director of Nursing regarding the Rail Assessment and Informed Consent, Evaluating Side Rail Assessment and Informed Consent, Evaluating Policy (Side Rail Assessment Evaluating Policy (Side Rail Assessmen	e Rail ass any ail log indings when a y, I by the distant, mended spital and educe 0, art of ditiated cryiced or the mg but on of
If continuation sheet Page 2 of an		,, romana versions (Unsolete Event ID;9D8D12	Faci	IIII. There is a second of the	inuation sheet Page 2 of 38

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 221} Continued From page 1 completed prior to the use of side {F 221} three residents reviewed. rails, Pre-Restraint Assessment, Physical Restraint Assessment The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit (when, on whom, why, and how conducted on March 12, 2012, revealed the the assessment is to be corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. completed), the risk of Non-compliance for F-221 continues at a "E" level entrapment associated with side citation (potential for more than minimal harm). rail use and how to obtain bed zone measurements per the FDA The findings included: "best practice" standards on Validation of the Credible Allegation of 2/29/12. All staff including new Compliance was accomplished through medical record review, review of facility policy, hires, contracted staff (performing observation, and interview with the nurses, direct care) and staff on leave of nursing assistants, and administrative staff. The facility provided evidence fall risk assessments absence will be in serviced by the and side rail assessments were completed for all Administrator, Maintenance residents, with removal of side rails when Director and/or the Director of indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment Nursing regarding but not limited risk. The facility provided evidence of in-service to: the completion of Side Rail for all staff and random audits to ensure compliance. Assessment and Informed Consent, Evaluation for the use of The facility will remain out of compliance at a "E" level until it provides an acceptable plan of Side Rails to be completed prior correction to include continued monitoring to to the use of side rails. Preensure the deficient practice does not recur and Restraint Assessment, Physical the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Restraint Assessment (when, on Committee. whom, why, and how the assessment is to be completed),

Event ID: 9D8D12

Facility ID: TN6201

the risk of entrapment associated with side rail use and how to

If continuation sheet Page 2 of 38

PRINTED: 03/14/2012 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) NO. O		OMB NO. 0938-0391		
AND PLAN (DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
NAME OF S	POWER OF COLUMN	445457	B. WING _		R 03/12/2012		
	PROVIDER OR SUPPLIER	CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354				
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	HILD BE COMPLETION		
	three residents revi The facility provided Compliance on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was ac record review, revie observation, and int nursing assistants, a facility provided evic and side rail assess residents, with remo- indicated, and evide were obtained to red risk. The facility pro- for all staff and rand compliance. The facility will rema level until it provides correction to include ensure the deficient the facility's correction	d a Credible Allegation of the 5, 2012. A revisit high 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). det: edible Allegation of complished through medical with of facility policy, erview with the nurses, and administrative staff. The lence fall risk assessments ments were completed for all avail of side rails when note bed zone measurements duce or eliminate entrapment vided evidence of in-service om audits to ensure in out of compliance at a "E" an acceptable plan of continued monitoring to practice does not recur and the measure could be ted by the Quality Assurance	{F 221}	per the FDA "best practice" standards prior to working scheduled shift. (d) Facility staff was in-service 2/6/12, 2/7/12, 2/8/12, 2/9/12, 2/13/12, 2/17/12, and/or 2/24/12 the Administrator, Maintenanc Director and/or the Director or Nursing regarding but not limit the completion of Side Rail Assessment and Informed Con Evaluation for the use of Side I to be completed prior to the use side rails, Pre-Restraint Assess Physical Restraint Assessment (when, on whom, why, and how assessment is to be completed) risk of entrapment associated wide rail use and how to obtain zone measurements per the FD. "best practice" standards and agon 2/29/12. Another in-service presented by the Administrator 3/15/12 to review survey findin and the plan of correction.	their ed on 2 by e f ited to: sent, Rails e of ment, w the the vith bed A gain e was on egs		
			, aciii;	If contin	uation sheet Page 2 of 38		

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE COMPI	0. 0938-03 SURVEY LETED
IAME OF F	PROVIDER OR SUPPLIER	445457	B. WING	3	R 03/12/2012	
EAST TE	NNESSEE HEALTH	77.55499 (54.46) 20.565	8	STREET ADDRESS, CITY, STATE, ZIP COD 465 ISBILL RD	E 03/	12/2012
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF GORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	NIOIN DO	COMPLETE DATE
Ties continued the continued t	conducted on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for citation (potential fo The findings include Validation of the Cre Compliance was accrecity review, review observation, and intenursing assistants, a facility provided evidend side rail assessment and evidence obtained to red isk. The facility provider all staff and randompliance. The facility will remain evel until it provides a correction to include consure the deficient pare facility's corrective eviewed and evaluate ommittee.	d a Credible Allegation of the 5, 2012. A revisit in 12, 2012, revealed the inplemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). d: dible Allegation of complished through medical with of facility policy, erview with the nurses, and administrative staff. The ence fall risk assessments ments were completed for all wall of side rails when note bed zone measurements use or eliminate entrapment rided evidence of in-service in audits to ensure. In out of compliance at a "E" an acceptable plan of continued monitoring to ractice does not recur and a measure could be and by the Quality Assurance.	{F 221	(e) The Administrator con the Q-Source representative registered the Director of Nursing, Assistant Director Musing, Assistant Director MDS Coordinator for a PRestraint & Pressure Ula Regional Collaborative In Session on April 10, 2012 (t) Upon admission/readmissionsidents will be assessed us Evaluation for the use of Sid Assessment tool by the Charror Nursing Administration for appropriateness of side rails the least restrictive device), side rail evaluations will be rewith significant changes, at a minimum of quarterly and/or needed by the charge nurse, M Coordinator and/or nursing administration. The least restrictive device in	or of or and chysical cer cearning sion, ing the e Rail ge Nurse or the cusing Further eviewed as ADS rictive raint in the colles, edules, edules,	
MS-2567(0)	2-99) Previous Versions Obs	Olpte		assistive devices, reclining /roc	ker	
		Event ID; 9D8D12	Facility			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 221} | Continued From page 1 chairs, drop seats, tilt back chairs, {F 221} three residents reviewed. family visits) have been attempted without success. A Pre-Restraint The facility provided a Credible Allegation of Assessment will be completed by the Compliance on March 5, 2012. A revisit charge nurse or by a member of the conducted on March 12, 2012, revealed the corrective actions implemented on March 5. Nursing Administration Staff prior to 2012, removed the Immediate Jeopardy. the use of a restraint. The Pre-Non-compliance for F-221 continues at a "E" level Restraint Assessment will guide the citation (potential for more than minimal harm). nurse in making a decision if a The findings included: restraint is recommended and/or offer alternative ideas (on the back of Validation of the Credible Allegation of Compliance was accomplished through medical form) that may reduce the risk of record review, review of facility policy, injuries associated with observation, and interview with the nurses, falls/restraints for those residents at nursing assistants, and administrative staff. The high risk for falls without the use of a facility provided evidence fall risk assessments and side rail assessments were completed for all physical device. An alternative residents, with removal of side rails when intervention can be attempted based indicated, and evidence bed zone measurements on the individual resident's Prewere obtained to reduce or eliminate entrapment Restraint Assessment in no specific risk. The facility provided evidence of in-service for all staff and random audits to ensure order. The Pre-Restraint Assessment compliance. can be updated on an ongoing basis for interventions that have been The facility will remain out of compliance at a "E" level until it provides an acceptable plan of attempted without success with the correction to include continued monitoring to date written to the side of the ensure the deficient practice does not recur and intervention attempted. If a the facility's corrective measure could be restraint is recommended, the reviewed and evaluated by the Quality Assurance Committee. resident will be assessed at a minimum of quarterly and/or as

FORM CMS-2567(02-99) Provious Versions Obsoleto

Event ID: 9D8D12

Facility ID: TN6201

needed to determine if the restraint remains an appropriate intervention or if a reduction can be attempted.

After the completion of an

If continuation sheet Page 2 of 38

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Т			OMB NO	. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		TIPLE CONSTRUCTION ING	(X3) DATE S COMPLE	URVEY
NAME OF F	20014000	445457	B. WIN	۷Ģ,		1	R
	PROVIDER OR SUPPLIER	CARE			TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD	03/1	2/2012
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			MADISONVILLE, TN 37354		
PREFIX TAG	I VOCALI DELICIENT.	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	INDE	COMPLETION DATE
	conducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconductive actions in 2012, removed the Non-compliance for citation (potential for The findings included Validation of the Crocompliance was acrecord review, review observation, and intruursing assistants, afacility provided evide and side rail assess residents, with removed indicated, and evided were obtained to reconductive and side vice were obtained to reconduct to the conductive actions in the conductive and side rail assess residents, with removed to the conductive actions in the con	d a Credible Allegation of tch 5, 2012. A revisit h 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). The detail of facility policy, erview with the nurses, and administrative staff. The lence fall risk assessments ments were completed for all and of side rails when noce bed zone measurements will of side reliminate entrapment will of side reliminate entrapment.	{F 2:	21)	Evaluation for the use of Side assessment and/or a Pre-Restr Assessment, the Maintenance Director or Maintenance Assis will be notified by the nurse or least restrictive side rails need achieve the resident's highest physical functioning status. The Maintenance Director or Assis will place the appropriate side on the resident's bed measuring Zone using a standard tape meadocumenting his findings on the Rail Log. The Maintenance Director of Assis will place the appropriate side on the resident's bed measuring Zone using a standard tape meadocumenting his findings on the Rail Log. The Maintenance Director of Channes and a return demonstration was performed by each charge (2/7/12 – 3/1/12). If a resident' condition changes that may requenchange in the side rail type, the	stant f the ed to e tant rails g each asure, e Side rector rge on nurse 's	*
	correction to include ensure the deficient the facility's corrective reviewed and evalua Committee.	in out of compliance at a "E" an acceptable plan of continued monitoring to practice does not recur and e measure could be ted by the Quality Assurance			must first complete a new Evaluation for the use of Side Rail Assessment notify the physician to obtain not orders, then notify the Maintena Director and/or Assistant for placement. Side rails will be measured each time there is a clin the side rail type, quarterly, an needed by the Maintenance Director Assistant.	nation nent, ew nnce nange nd as	2
UNIG-200/	(02-99) Previous Versions Of	Osolete Event ID:9D8D12	F	acili	ty ID: TN6201 If continu	<u> </u>	

If continuation sheet Page 2 of 38

PRINTED: 03/14/2012 FORM APPROVED

AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	L(VO) No		OMB NO	M APPRO\ D. 0938-0:	
	es esterographica de la companya de	IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
		445457	B, WIN		COMP	COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	1.0457	5, 77117		1	R	
	NNESSEE HEALTH	CARE		STREET ADDRESS, CITY, STATE, ZIP CO 465 ISBILL RD	DOE 03/	12/2012	
(X4) ID PREFIX	SUMMARY ST	TEMENT OF DEFICIENCIES	,	MADISONVILLE, TN 37364			
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	PPO (COCO)		COMPLETE DATE	
{F 221}		de 1					
	three residents revi	ewed	{F 22	(g) The Regional Nurse			
i				Consultant in-serviced	ha MDa		
	Compliance	a Credible Allegation of		Coordinator and the Sta	rie MD2		
1	conducted on Maral	ch 5, 2012. A revisit		Coordinator/Parkets	iting		
	corrective actions in	12, 2012, revealed the		Coordinator/Back Up M	ID\$	1	
ļ	Non serviced the	mmediate Jeopardy.		Coordinator on 2/21/12	and		
	citation (notable)	F-221 continues at a "E" level		2/22/12 on the completion	on of		
- [2		man minimal narm).		accurate assessments and	1	ļ	
The findings included: Validation of the Credible Allegation Compliance was accomplished thro record review, review of facility pairs	d:		developing/revision of c	are plans			
				to reflect the resident's c	urrent		
	dible Allegation of		medical condition. The	MDS			
ſ	ecord review review	omplished through medical		Coordinator will obtain a			
10	bservation and into	by lacility policy,		physician's order, initiate	D		
fa	acility provided	nd administrative staff. The		Restraint Assessment, co	a 1 (C-		
a	nd side rail account	ince fall risk assessments		an Evaluation for the Use	inpiete		
re	Sidents with ross.	welle completed for all		Rails and obtain - Sit a	of Side		
1.10	IQICated and outst-	Lenge I allo MUSU		Rails, and obtain a Side R	lail		
ris	sk The facility	ce bed zone measurements ice or eliminate entrapment ded evidence of in	Ì	Assessment and Informed		12	
10	all staff and rando	ded evidence of in-service		Consent form for newly c	oded		
co	mpliance.	in audits to ensure	1	side rails on the MDS alo	no with		
T	e facility			revising the resident's care	nian	9	
lev	el until it provides	out of compliance at a "E"	1	If the side rail is a continu	ation		
ÇO	rection to include	agochignie bigu of		from the resident's previou	15		
l en	Sure the deficient	on to a serious de la company		assessment, a Physical Res	traint		
rev	facility's corrective	measure could be		Assessment will be review	nd and		
Co	mmittee.	measure could be d by the Quality Assurance		updated to determine if the	eu and		
1	* 00	0 0		resident is a candidate for r			
-			1	reduction. The T	estraint		
				reduction. The Interdiscipli	nary		
			1	Team (not limited to:			
4D 000=:				Director/Assistant Director	of		
10-2567(02.	99) Previous Versions Obsoli	ete		Nursing, MDS Coordinator,		1	
		Event ID:9D8D12	Facilia	ID: TN6201		- 1	

04/02/2012 08:11 4234424465

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED

ND PLANCE	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA	TOWN AND		OMB NO	0.0938-039
HAD FENING	DE CORRECTION	IDENTIFICATION NUMBER:	A, BUII	ULTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
NAME OF S		445457	B, WIN	G	-	R
	PROVIDER OR SUPPLIER		· 	STREET ADDRESS ATTA	03/	2/2012
	NNESSEE HEALTH	CARE		STREET ADDRESS, CITY, STATE, ZIP 465 ISBILL RD	CODE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	MADISONVILLE, TN 37354		<u> </u>
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
{F 221}		ge 1	(E oc	Social Services, Activ	ity	
	three residents revi	ewed.	{F 22	Director) will also dis		
	The facility provided	d a Credible Allegation of		residents with restrain		
		CD 5 71127 A		in their Fall Focus Me	eting for	
	CONTRACTOR OF MAIL	h 12, 2012. A revisit h 12, 2012, revealed the inplemented on March 5,		modification and/or re	duction.	
	A LA LEI HOVEU ME	Immediate learner		Resident and families		
1	LACTICOLIDISANCE TO	E-221 confinues of a della		notified of scheduled		
	(potential to	more than minimal harm).		meetings by the MDS	•	
	The findings included: Validation of the Credit	ed:		Coordinator prior to the	e residents	
		edible Allegation of		next scheduled assessn	nent and/or	
	Sompliance was ac	Compliebad thereas a		as needed to assist in d	eveloping a	
	. a a till i CALCAN' LEALE	M OT TOCILIS Action.		plan of care that meets	the	
		erview with the nurses, and administrative staff. The		resident's personal/med	dical goals.	
				The MDS Coordinator	will utilize	
	residents, with remo	ments were completed for all		information provided in		
				morning QA meeting,		
1	risk. The facility prov	vided avide		report, resident's medic		
		om audits to ensure		and communication fro		
	compliance.			residents, and/or famili	es when	
13	The facility will remai	n out of compliance at a "E"		completing resident ass		
				to ensure accuracy. On	2/23/12	
e	ensure the deficient	continued monitoring to		the Interim MDS Coord		
j ti	he facility's corrective	e measure could be		in-serviced by the Regi	onal Nurse	
	committee.	e measure could be ged by the Quality Assurance		Consultant on accuracy	when	
!	***	0. 1		completing MDS's and	the	
	2.			development and revisi	on of care	
				plans, along with recent	survey	
				deficiencies. On 3/5/12		
A CMS-2567(02-99) Previous Versions Ob			Regional Nurse Consult	ant in-	
	A STANDAR A SELZIOUS OF	solete Event ID:9D8D12	Far	ulity ID: TN6201	continuation sheet	

04/02/2012 08:11

STATEME! AND PLAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPLE CONSTRUCTION	OMB NO	M APPROV 0. 0938-03	
		IDENTIFICATION NUMBER:	A. BIJILD		(X3) DATE		
NAMEOR		445457	B. WING		1	R	
	PROVIDER OR SUPPLIER				03/	12/2012	
EAST T	ENNESSEE HEALTH	CARE	29	TREET ADDRESS, CITY, STATE, ZIP CODE 485 ISBILL, RD			
(X4) ID PRÉFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	MADISONVILLE, TN 37354			
TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETIC DATE	
{F 221}	Continued From pa	30e 1					
	three residents rev	iewed	{F 221}	serviced the MDS Coordin	ator on		
	Ť	Manage Allerant St.		documenting (communication	ion)		
	Compliance on Ma	d a Credible Allegation of rch 5, 2012. A revisit		changes made to the resider	nt's		
	conducted on Marc	th 12, 2012. A revisit		plan of care on the 24 hour	report.		
				(h) The Regional Director o	£		
				Operations in-serviced the	1		
	citation (potential fo	r more than minimal harm).		Administrator, the Maintena			
	The findings include	ed:		Director and the Maintenance	псе		
	Validation of the C-	adib to a u		Assistant regarding the FDA			
1	Validation of the Cre Compliance was acc			Safety Alert: Entrapment Ha	zond.		
	record review, review	w of facility policy		with Hospital Bed Side Rails	zatus		
				shared by the surveyors during	and		
	facility provided avid	and administrative staff. The		facility demonstration of	ng		
1	and side rail assess	ments were completed for all	1	measuring bed zones (include	•		
	indicated, and eviden	val of side rails when		flat and articulated positions)	ed		
1	were obtained to red	val of side rails when nee bed zone measurements uce or eliminate entrapment	1	2/7/12. The Maintenance	on		
1,	risk. The facility prov	rided evidence of in-service		Director and the Maintenance			
18	for all staff and rando compliance.	om audits to ensure		Assistant were able to	·		
				demonstrate	1		
1	The facility will remain	n out of compliance at a "E"		demonstrate competency thro	ugh		
10	correction to include	acceptable plan of		a return demonstration on 2/7/	/12		
e	insure the deficient a	monitoring to		on measuring the bed zones in	flat		
Tre Tre	he facility's corrective	measure could be		and articulated positions (related to the infe	ed		
C	committee.	e measure could be ged by the Quality Assurance	1.	to the information provided			
-	Market B	Access and a second a second and a second and a second and a second and a second an	1	during the survey). The Region	nal		
	24		1 1	Director of Operations also in-	. [
1			8	serviced the Maintenance Direct	ctor		
			a	ind Assistant on 2/13/12	1		
C) (0 02==:			r	egarding The FDA Hospital Re	ed		
2.10-K307(U	02-99) Previous Versions Obs	plote Event ID: 9D8D12	S	ystem Dimensional and	53784		

Facility ID: TN6201

If continuation sheet Page 2 of 38

PAGE 31/99

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID

AND PLAN	OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MIII	TIPLE CONCERNA	FUR	D: 03/14/20 M APPROV D: 0938-03
		SERVICION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE	SURVEY LETED
NAME OF	000	445457	B. WING		CONT	
	PROVIDER OR SUPPLIER				02/	R 12/224=
EAST T	ENNESSEE HEALTH	CARE	ST	REET ADDRESS, CITY, STATE, ZIP COL	DE 031	12/2012
(X4) ID	SUMMARYAN		(8)	465 ISBILL RD MADISONVILLE, TN 37354		
PRÉFIX TAG	REGULATORY OF	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFY MEDICAL PROPERTY OF THE PROPERTY	I ID			
		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RECTION SHOULD BE	(X\$)
{F 221}	C			CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
(ZZ1)	KI IIIOI I POPI	ge 1	/- -			
ļ	three residents reviewed. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit		{F 221}	Assessment Guidance to	Reduce	
				Entrapment dated March 2006.	10,	
į						
	corrective actions	on 5, 2012. A revisit		4. (a) The Administrator	or	
- 1	2012, removed the I	ipremented on March 5.		Director of Nursing will r	evious	
ĺ	Non-compliance for	mmediate Jeopardy. F-221 continues at a "E" level	1	the Side Rail Log daily (N	Annda.	
	citation (potential for	F-221 continues at a "E" level more than minimal harm).	1	randay) to ensure the docu	Imant :	
1.	Validation of the Credible Allegation of Compliance was accomplished through medical			completed as needed to re-	flect the	
				resident's current side rail	1	
- (measurements for the next	90	
1				days; then weekly for 90 d	ave if	
10	bservation, and inte	roiew with the nurses,		compliance has been main	toinad.	
/ fa	Cility provided and	ru administrative staff The		then randomly thereafter	I f ot	
i a	nd Side rail account	1 disk assessments		any point compliance is no	timat	
1.76	Sidents with	were completed for all		the party will resume monit	towin -	
W	ere obtained to	e ded zone measurements	1	ually (Monday-Friday) unti	i i	
113	ere obtained to reduce or eliminate entrapments sk. The facility provided evidence of in-service ompliance.			compliance is maintained.		
cc	mpliance.	audits to ensure		(b) The Director of Nursing		
T	ne facility will remain out of compliance at a "E"			Assistant Director of Nursin		
lev	el until it provides a	out of compliance at a "E"	I	RN Weekend Supervisor wi	g, or	
ÇÜ	vel until it provides an acceptable plan of prrection to include continued monitoring to sure the deficient practice does not recur and riewed and evaluated by the Quality Assurance in mittee.		10	conduct daily audits for on a		1
the			t)	hrough facility walking rou	lays	
rev			re	eview of the 24 hour report,	uas,	
Co	mmittee,	Assurance	p	lans, Nurse Aide	care	
		*	C	ommunication Sheets,		
1			E	valuation for the Use of Sid		1
			Ra	ails, and Nurse Event notes	e	
			en	sure the appropri	to	
S-2567(02-	99) Previous Versions Obsole			sure the appropriate proced	ures	1
	-110 003016	Event ID:9D8D12	Facility ID:			1

NO BLANC	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA	LOVEN NUMBER		OMB NO	. 0938-03
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 445457 NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING_				
		1		03/1	2/2012	
	NNESSEE HEALTH	2	1 4	REET ADDRESS, CITY, STATE, ZIP CODE 166 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	- ID			
TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	MILLORE	COMPLETIC DATE
{F 221}	three residents reviewed.		(F 004)	and policies are being foll	1 10	<u> </u>
-			{F 221}	compliance is a series to the	owed, if	
			8	compliance is maintained	audits	
	Compliance on Ma	d a Credible Allegation of such 5, 2012. A revisit		will reduce to weekly audi	ts times	
ĺ	AALIA OLI MALL	th 12 2012 reventant		90 days, then random audi	ts as	
	Source actions	mniementod on March =		long as compliance is mair	tained	
	TO ISTITUTED THE	Immediate leases		If at any time compliance i	s not	
	TOUT-COMBINION TO	r =-221 continue		met, daily audits will resum	e until	
1	- August (potential to	or more than minimal harm).		compliance is obtained. T	he onig	
	The findings includ-	ed:		audit findings will be revie	1	
			İ	the morning Outlier A	wea	
i	Compliance was a	edible Allegation of		the morning Quality Assura	ınce	
110	TOTAL CALCAN LEADE	ecomplished through medical	İ	Meeting (Monday-Friday)	and	
100	ONSET VALIOIT, AND IN	TAITURAL LIGHT ALL		review with the Medical Di	rector	
0.10	THE PARTY OF THE P	And administration		in the quarterly QA meeting	and	
				as needed.		
1	residents, with remo	or all	1		ĺ	
					1	
1	were obtained to re-	duce or eliminate entrapment		Completion Date: 3/22/12	1	
	compliance.	lom audits to ensure				
f.		ļ			Ì	
	the facility will rema	in out of compliance at a "E"				
, c	correction to include	an acceptable plan of				
e	nsure the deficient	proctice of monitoring to	}			
ti	he facility's correctiv	/e measure could be	I			
100	The state of the s	ited by the Quality Assurance	1		1	
10	Committee.	, out an ite				
į				E 22		
1	*				ł	
ļ						
į		1				
GMS-2567(02-99) Previous Versions O					
	LIOUS ARIZIOUS O	bsolote Event ID: 9D8D12			- 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445457 NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
						R	
		B, WING		03/	12/2012		
EAST TE	ENNESSEE HEALTH	CARE	4	REET ADDRESS, CITY, STATE, ZIP 165 ISBILL RD MADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	I GACH DEFICIENT	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 221}	Continued From p	age 2	{F 221}				
		,					
{F 226} SS=E	mistreatment, negle	, ETC POLICIES	{F 226}	F 226 483.13(c) Develop/Impl Abuse/Neglect, Etc Poli	ement icies		
in ti ti	y. Based on medical r nvestigations, facilit he facility failed to r imely for three resid	record review, review of facility by policy review, and interview, eport an allegation of abuse thents (#13, #10, #83) of four ations of abuse reviewed.		Requirement: The facility must develop implement written policies procedures that prohibit reglect, and abuse of residmisappropriation of resid	es and nistreatment, dents and		
R S C	esident #10 was ad eptember 9, 2011, erebrovascular Acc ementia.	dmitted to the facility on with diagnoses including cident, Diabetes, and investigated		1. A thorough investigation conducted by Director of Services and the facility A regarding the allegations or residents #13, 10, and 830. The alleged suspect is no	on was Nursing Administrator of abuse for		

FRINTED: 03/14/2012 FORM APPROVED

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLF CONSTRUCTION G	(X3) DATE COMPI	E SURVEY PLETED	
445457		B. WING_		_	R	
IAME OF PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP 65 ISBILL RD IADISONVILLE, TN 37354	CODE	12/2012	
LUGLIN I TOUCH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
Nursing) received: (10:30 p.m.) The or that (CNA #4) (cent to (Director of Nursing) had sport mean and rude material also gotten rough with the charge nurse of the charge nurse of the residents. It ask report to the charge (CNA #4) stated that someone was at the resident #83 was at March 16, 2011, with Dementia, Alzheime Review of the facility by the DON, dated Nilling in my office. (cassisting (CNA #4) stated rails down and rough over almost out of be (CNA #5), and states (resident #83) becaute Resident #13 was ad March 21, 2008, with	Nursing (DON), dated 1, revealed "(Director of a call from the facility at 2230. harge nurse on duty reported iffied nursing assistant) came sing) and reported that another ken to several residents in a nner and that (CNA #5) had with their care, and that (CNA about what to do to report it. It stated that the CNA (#5) in the left of the evening. I ge nurse to go and question the (CNA #4) whydid not a nurse on (CNA #4) shift, at every time that I tried a nurses station" I dmitted to the facility on the diagnoses including ar's Disease, and Dysphagia. I investigation #2 investigated lovember 14, 2011, revealed to this am (CNA #4) was CNA #4) reportedwas in providing care to (resident that (CNA #5) put both side ally pushes (resident #83) and then pulledtowards is "you have to be rough with see (resident #83) holds stiff."		employee at the facility patterns were reviewed all residents are free from 2. The Social Worker is residents with a BIM so than 13 on 3/20/12. The Administration team per assessments to observe abuse for residents with less than 13 completed is new findings of abuse with less than 13 completed is new findings of abuse with less than 13 completed is new findings of abuse with less than 13 completed is new findings of abuse with less than 13 completed is new findings of abuse with less than 13 completed is staff addressing the facility and procedures regarding violations. An annual inscheduled in September policy and as needed. 4. The Social Service Directly and as needed. 4. The Social Service Directly and as needed. 5. The for four (4) consecutive with the social service will be interview that any alleged violations identified, properly investing the facility and procedures. Findings of will be discussed in the modulative Assurance meeting quarterly QA Committee in the social service in the modulative Assurance meeting quarterly QA Committee in the social service in the modulative Assurance meeting quarterly QA Committee in the social service in the modulative Assurance meeting quarterly QA Committee in the social service in the modulative Assurance meeting quarterly QA Committee in the social service in the modulative Assurance meeting quarterly QA Committee in the social service	on abuse. Interviewed core greater Nursing rformed skin for signs of BIM score by 3/19/12. No were noted. Inducted by the prices and the core greater care ity policies galleged service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility. Interviewed core greater was a service is per facility.		

IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION	(X3) DATE :	SURVEY ETED
		445457	B. WING		-	R
NAME OF	NAME OF PROVIDER OR SUPPLIER				03/	12/2012
EAST T	ENNESSEE HEALTH	CARE	١	TREET ADDRESS, CITY, STATE, ZIP 465 ISBILL RD MADISONVILLE, TN 37354	CODE	
(X4) ID PREFIX TAG	I CAUT DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 226}	Review of the facility the DON, dated "(CNA #4) reported last round (CNA #5 care of (resident #1 #5) roughly pushed clean (resident #13) state and that (CNA #5) I was up(CNA #4) rude with resident # #5) kept acting like the bedresident # #5) to get out of the	ty investigation #3 investigated November 14, 2011, revealed to (DON) that on (CNA #4) assisted (CNA #4) in the 3). (CNA #4) reported (CNA (resident #13) over socould (CNA #4) reported that dwas going to fall out of bed aughed and said that the rail reported that (CNA #5) got 13(CNA #4) reports (CNAwas going to pull resident off 13 got upset and told (CNA room"	{F 226	and Service meeting un consistent substantial c been met. Completion date: 3/22	ompliance has	
{F 272} SS=E	suspected abuse mi immediatelycompli occurrences to inclusion February 16, 201: CNA #4 did not follow the allegations of abute 483.20(b)(1) COMPFASSESSMENTS The facility must contact comprehensive, accomprehensive, accompre	ete an investigation on all de appropriate information" ON in the small dining room 2, at 2:40 p.m., confirmed with the facility policy and report use immediately. REHENSIVE duct initially and periodically curate, standardized nent of each resident's	{F 272}	F 272 483.20(b)(1) Comprehent Assessments SS=E Requirement: The facility must conduct periodically a comprehent accurate, standardized repassessment of each resider functional capacity. A fact make a comprehensive assessment of each resider functional capacity.	initially and Sive, roducible nt's	
r	coluciii assessment	dent's needs, using the instrument (RAI) specified sessment must include at		resident's needs, using the assessment instrument (RA by the State.	resident	

04/02/2012 08:11

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

EAST TENNESSEE HEALTH CARE

{F 272} Continued From page 5 least the following:

AND PLAN OF CORRECTION

(X4) ID PREFIX

TAG

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six-residents (#41, #60, #18, #83, #55, #57) of forty three

The facility provided a Credible Allegation of

.0.	.2 00.11 120	. , , , , , , , , , , , , , , , , , , ,					
R	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				PRINTEL): 03/14/2012
-, -	OF DELICIENTES	(X1) PROVIDER/SUPPLIER/CLIA				OME NO	1 APPROVEC 0. 0938-0391
N C	F CORRECTION	IDENTIFICATION NUMBER:	(X2) N	ד,וטו	TIPLE CONSTRUCTION	(X3) DATE	2. 0938-0391
			A. BU	ILDIF	vg	COMPL	ETED
_		445457	B. WI	NG			R
F P	ROVIDER OR SUPPLIER			_		03/	12/2012
TE	NNESSEE HEALTH O	ADE		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TENNESSEE HEALTH CARE				4	165 ISBILL RD		
.	SUMMARY STA	TEMENT OF DEFICIENCIES	لـــــــــــــــــــــــــــــــــــــ	n	MADISONVILLE, TN 37354		
_	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	MILDOR	(X5) COMPLETION DATE
			-	_	DEFICIENCY)		
1	Continued From pag	je 5	(F 0-	701	Corrective Action Plan:		
	east the following:		{F 27	(2)	CONTECUTE ACTION PIAN:		
1	dentification and de	mographic information;		- 1	1. (a) Upon review of the Fa	ll Risk	l i
	Customary routine; Cognitive patterns;				Assessment on 2/6/12 comp	leted	
0	Communication;	i			by the licensed nurse the sys	stematic	
1	/ision:			- 1	review of risk factors indica	ted a	
V	flood and behavior p	eatterns:			risk score of 24 (high risk) f	or	1
	Sychosocial Well-he	ina-		-	resident #41. Based on the	risk	
Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;				-	factors from his Fall Risk	XIDA	
					Assessment it was determine	ed that	
D	ental and nutritional	d health conditions;			he was not a candidate for th	DO 1750	
0	KIN conditions:	status;		i	of side rails due to impaired	ic use	
A	ctivity pursuit:				judgment, incontinence, and	hiotom	l l
M	edications;				of falls from his bed. The s	ido	
D	pecial treatments an	d procedures;			rails were removed on 2/6/12) hv.	1
					the Maintenance Director. T	ha	
the	additional assess	nmary information regarding nent performed on the care			nursing administration staff	iie	1
		completion of the Minimum		1	communicated changes made	0 40 41	
Da	ita Set (MDS), and	The Minimum	31		resident's plan of care (remo	e to the	1
DC	cumentation of part	icipation in assessment.			side rails and low bed with o	valor	
					mat) to the direct area!	ne ,	1
(2)					mat) to the direct caregivers Nurse Aide Communication	on the	1
		ł		1	Workshart and I do		
					Worksheet and the Care plans	on	
		į			2/6/12. On 2/17/12 a telephor	ne	
Thi	S DEOLUDE:			1	order was obtained by the cha	rge	
y:	" VEKINENT	is not met as evidenced			nurse and the Director of Nurs	sing	1
					to discontinue the resident's b	ed	Ţ
		ord review, observation, y failed to conduct a		1	and chair alarm and use a sens	or	
]	pressure pad for his bed and cl	hair.	
14	, #60, #18, #83, #5	5. #57'r of forty three			The resident remains on a low	bed	

FORM CMS-2567(02-99) Previous Versions Obsolete

residents reviewed.

Event (D: 9D8D12

Facility ID: TN8201

with one mat at bedside after receiving a telephone order from

the physician on 2/23/12. The resident's care plan was updated on

If continuation sheet Page 6 of 38

4234424465 04/02/2012 08:11 EAST IN HEALTH CARE PAGE 37/99 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES PRINTED: 03/14/201 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVE IDENTIFICATION NUMBER: OMB NO. 0938-039 (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID MADISONVILLE, TN 37354 PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE {F 272} DEFICIENCY) Continued From page 5 2/24/12 by the Interim MDS least the following: {F 272} Identification and demographic information; Coordinator to reflect the current Customary routine; orders and interventions (other Cognitive patterns; interventions: involve in activities, Communication: slip resistant footwear, may place Vision: in the sight of staff when awake, Mood and behavior patterns; Psychosocial well-being; rest periods as needed, family at Physical functioning and structural problems; bedside sessions throughout the day, get patient up when trying to Disease diagnosis and health conditions; get out of bed, offer snacks, attempt Dental and nutritional status; to keep resident dry or clean Skin conditions; immediately after incontinent Activity pursuit; Medications: episode). The care plan was Special treatments and procedures; audited by the Nursing Discharge potential; Administration Staff to ensure that Documentation of summary information regarding the plan of care had been updated the additional assessment performed on the care areas triggered by the completion of the Minimum to reflect the resident's current Data Set (MDS); and status on 2/24/12. Resident was Documentation of participation in assessment. hospitalized from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 This REQUIREMENT is not met as evidenced for transfers. The resident no Based on medical record review, observation, longer requires constant and interview, the facility failed to conduct a supervision for the prevention of comprehensive assessment on six residents falls. He is on the FROG Program

residents reviewed.

(#41, #60, #18, #83, #55, #57) of forty three

that provides closer observation

from various staff members.

Resident was transferred to the hospital again on 3/9/12 after visit 4234424465

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/20 STATEMENT OF DEFICIENCIES FORM APPROVI (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-03 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL In PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 272} | Continued From page 5 Coordinator completed a discharge least the following: {F 272} Identification and demographic information; assessment on 3/9/12. Resident Customary routine; was readmitted on 3/15/12 with Cognitive patterns; admitting Charge Nurse completing Communication; Fall Risk Assessment and Vision; Evaluation for the Use of Side Mood and behavior patterns; Psychosocial well-being; Rails with the recommendation to Physical functioning and structural problems; be that side rails were not indicated Continence; at that time. Resident's care plan Disease diagnosis and health conditions; was updated on 3/21/12 with a Dental and nutritional status; significant change assessment Skin conditions; Activity pursuit completed by the MDS Medications: Coordinator. Resident's care plan is Special treatments and procedures; updated per MDS and/or Charge Discharge potential: Nurse on ongoing bases and as Documentation of summary information regarding the additional assessment performed on the care needed with any new orders, areas triggered by the completion of the Minimum interventions, or changes. Data Set (MDS); and Documentation of participation in assessment. (b) Resident# 60 was discharged to the hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint. The resident will be reassessed upon This REQUIREMENT is not met as evidenced return to the facility. The care plan was reviewed by the Interim MDS Based on medical record review, observation, Coordinator and reflects the and interview, the facility failed to conduct a comprehensive assessment on six residents resident's current status as of (#41, #60, #18, #83, #55, #57) of forty three 2/26/12. The care plan was audited residents reviewed. by the Nursing Administration Staff to ensure that the plan of care The facility provided a Credible Allegation of had been updated to reflect the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

resident's current status on 2/26/12.

If continuation sheet Page 6 of 38

4234424465 EAST IN HEALTH CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES PRINTED: 03/14/ AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPRO IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-((X5) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETI DATE {F 272} Continued From page 5 DEFICIENCY) least the following: Resident was transferred to hospital {F 272} Identification and demographic information; on 2/26/12. The Interim MDS Customary routine; Coordinator completed a Discharge Cognitive patterns; Assessment on 2/29/12 which Communication; reflected the use of side rails as a Vision: Mood and behavior patterns; restraint (as 1/2 rails were used until Psychosocial well-being; 2/23/12 during the 7 day look back Physical functioning and structural problems; period). The resident was Continence; reassessed upon return to the Disease diagnosis and health conditions; facility on 3/12/12 by the admitting Dental and nutritional status; Skin conditions; Charge Nurse who completed an Activity pursuit; Evaluation for the use of Side Rails Medications; and a Fall Risk Assessment with Special treatments and procedures; Discharge potential; the recommendation for no side Documentation of summary information regarding rails indicated at this time. The the additional assessment performed on the care MDS Coordinator completed a 5 areas triggered by the completion of the Minimum day Readmission Assessment on 3/22/12. (A 14 day Assessment Documentation of participation in assessment. was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes. This REQUIREMENT is not met as evidenced (c) Resident #18 The side rails Based on medical record review, observation, that were in place during the and interview, the facility failed to conduct a survey were immediately changed comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three to full anti-entrapment rails on residents reviewed. 2/6/12 by the Maintenance Director after receiving a The facility provided a Credible Allegation of physician's order. The FORM CMS-2567(02-99) Previous Versions Obsolete measurements for the bed zones Event ID: 9D8D12 Facility ID: TN6201 If continuation sheet Page 6 of 38

4234424465

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/20 STATEMENT OF DEFICIENCIES FORM APPROVI (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-03 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE DEFICIENCY {F 272} Continued From page 5 were obtained by the Maintenance least the following: {F 272} Identification and demographic information; Director on 2/6/12 using a Customary routine; standard tape measure with Cognitive patterns; measurements. The Staffing Communication; Vision: Coordinator wrote a narrative Mood and behavior patterns; note in the nurses notes on 2/6/12 Psychosocial well-being; Physical functioning and structural problems; describing the resident with limited functional status using the Disease diagnosis and health conditions; Dental and nutritional status; side rails as a restraint. A Physical Skin conditions: Restraint Assessment was Activity pursuit: updated on 2/6/12 by the Staffing Medications: Special treatments and procedures; Coordinator for the use of side Discharge potential; rails. A Side Rail Assessment Documentation of summary information regarding the additional assessment performed on the care and Informed Consent was signed areas triggered by the completion of the Minimum by the family on 2/13/12. On Data Set (MDS); and 2/20/12 the MDS Coordinator Documentation of participation in assessment. completed an Evaluation for use of Side Rails with a reduction in side rails from full (antientrapment) to 1/2 rails, the physician was notified and order This REQUIREMENT is not met as evidenced was obtained for ½ side rails. The measurements for the bed zones Based on medical record review, observation, and interview, the facility failed to conduct a were obtained by the Maintenance comprehensive assessment on six residents Director on 2/20/12. On 2/23/12 (#41, #60, #18, #83, #55, #57) of forty three the resident was evaluated again residents reviewed. for side rail reduction by the The facility provided a Credible Allegation of Staffing Coordinator, the FORM CMS-2567(02-99) Previous Versions Obsolete resident's side rails was Event ID:9D8D12 Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PRINTED: 03/14/2 (X1) PROVIDER/SUPPLIER/CLIA FORM APPROL (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: OMB NO. 0938-0: (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD SUMMARY STATEMENT OF DEFICIENCIES (X4) ID MADISONVILLE, TN 37354 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE {F 272} DEFICIENCY DATE Continued From page 5 least the following: eliminated and the resident was {F 272} Identification and demographic information; placed on a low bed with mats. Customary routine; Cognitive patterns; On 3/5/12 resident rolled out of Communication; hed with a small laceration to Vision: upper lip with intervention to Mood and behavior patterns; Psychosocial well-being; check placement of furniture and Physical functioning and structural problems; remove if in pathway. Keep room Disease diagnosis and health conditions; free of clutter for safety, Bowel Dental and nutritional status; and bladder program to determine Skin conditions; habit time, and FROG Program. Activity pursuit: Medications, Care plan was updated to reflect Special treatments and procedures; new interventions for 3/5. 3/13 Discharge potential; Documentation of summary information regarding resident was found in room 129 the additional assessment performed on the care bathroom with one shoe on. areas triggered by the completion of the Minimum Resident had gotten up from her Data Set (MDS); and Documentation of participation in assessment. wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further This REQUIREMENT is not met as evidenced intervention was added to get up after breakfast as desires after Based on medical record review, observation, and interview, the facility failed to conduct a further investigation of fall on .comprehensive assessment on six residents 3/13. Fall on 3/17 where resident (#41, #60, #18, #83, #55, #57) of forty three residents reviewed. rolled from the bed in her sleep, bed was in lowest position with The facility provided a Credible Allegation of mats on both sides, no injury FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 908012

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE	M AFPI 0. 093.
			A. 8UILE	——— <u>—</u>	COMP	LETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING		1	R
	ENNESSEE HEALTH (000 TO 500 MW VIII	s	TREET ADDRESS	03/	12/201
		CARE		TREET ADDRESS, CITY, STATE, ZIP COL	Œ	o de Colonia
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
PRÉFIX TAG	REGULATORY OF LE	MUST BE PRECEDED BY FULL	I ID	PROVIDEDIO DI ANTES		
/C 0744		TING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE PPROPRIATE	COMPI DA
(F 272)	Continued From pag	je 5				
- 1	least the following.		(F 272)	noted, intervention to add	loog b	
1	Customanus de	mographic information;		moodles to define perimo	to	
ĺ	Customary routine, Cognitive patterns;	and and any		all above interest	ondia.	
	Communication			auded to the care plan.		1
- 1	VISIOD.			implemented. Resident's		
	Mood and behavior p	atterns;		plan is updated per MDS	care	
				Charge Nurse on an ongo	and/or	
(Continence;	ng; ind structural problems;	1	bases and as me	ıng	
1.	Disease diagnosis		1	bases and as needed with	any new	
	Dental and nutritional	status:	1	orders, interventions or al		
23	Skin conditions; activity pursuit;		1	Troopsyment Was complete	d on	
į IV	redications.		1	4/40/12 by the Staffing	1	
S	pecial treatments	1 000		Coordinator for the elimin	otion o	
D	ischarge potential;	procedures;		side rails and the use of a I	ation of	
10	PUUIIIPHISMAS A.	mary information regarding		with mats after receiving a	ow bed	
an	e additional assessm	ent performed on the care	1	physician's and		
l Da	III Set (MDev	The Minimum		physician's order. The car	e plan	
Do	cumentation of partic	cipation in assessment.		addited by the Murain a		
1	· · · partic	in assessment.		Administration Staff to one		
- 1				that the plan of care had be		
1		×		updated to reflect the reside	-41	
1				current status on 2/29/12.	in S	
This	REQUIREMENT is	not met as evidenced		(d) Resident #83 The		
Bas	sed on made	as avidenced		recapitalization orders were		
and	interview the feeting	review, observation,		signed by the	3	
. LCOM	Dreheneivo	railed to conduct a		signed by the physician for	2/2/12	
T(#47	-#60-#18-#93-#FF	#57) of fare		order for the	- 0	
resid	ents reviewed.	" / Or long three		and An assessment	1	** :
The f	acility pro		1	completed on 2/6/12 using -	n	
	acility provided a Cre	dible Allegation of		ASSESSMENT for the	and the same of th	
_		_		of % side rails completed by i	use	
2567(02-99) Previous Versions Obsolete		1	J A Stae rails complated		

PRINTED: 03/14/2012 FORM APPROVED

AND PLAN	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	LTIPLE CONSTRUCTION PING	(XE) DATE	OMB NO. 0938-03 (XE) DATE SURVEY COMPLETED	
		445457	B. WING			R	
NAME OF I	PROVIDER OR SUPPLIER	7.040)			03/	12/2012	
	ENNESSEE HEALTH		s	TREET ADDRESS, CITY, STATE, ZIP 4 465 ISBILL RD	CODE	12/2012	
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354			
PREFIX TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE	
ti a	Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutritiona Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su ne additional assess reas triggered by the	patterns; eing; and structural problems; and health conditions; al status; and procedures; and procedures; and procedures are the care	{F 272	MDS Coordinator indirestraint was recomme related to cognitive imprequiring physical assistant unaware of safety issue order was obtained on from the resident's phythe use of side rails as a On 2/20/12 an Evaluati use of Side Rail Assess completed by the MDS Coordinator indicating tresident was unaware of needs, cognitive impairing equiring physical assist	ended pairment, istance, and es. An 2/6/12 rsician for a restraint. on for the ment was the f safety ment, and		
Th by: Ba	is REQUIREMENT	is not met as evidenced ord review, observation,		the utilization of % side new Evaluation for the Side Rails was complete 2/23/12 by the Director Nursing for the reduction rails from % to ½. The Physical Restraint Assess was updated on 2/23/12 Director of Nursing for the restraint reduction and necessary.	erails. A use of ed on of on of side resident's esment by the		
res	1, #60, #18, #83, #! idents reviewed.	55, #57) of forty three		rails. On 2/28/12, an Evi	side		
The	facility provided a	Credible Allegation of		for the use of Side Rails Physical Restraint Assess	and		
13-2567(02-	99) Previous Versions Obso	lete Event ID: 9D8D12			SINCILL		

4234424465

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SU COMPLE		
			A. BUI				٦	
		445457	B. WI	4G		200	03/12/2012	
	ROVIDER OR SUPPLIER	CARE		40	EET ADDRESS, CITY, STATE, ZIP CODE 55 ISBILL RD IADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of s the additional assess areas triggered by ti Data Set (MDS); an	emographic information; patterns; peing; and structural problems; and health conditions; al status; and procedures; ummary information regarding sment performed on the care the completion of the Minimum	{F 2	72)	was completed by the Dire Nursing indicating the elim of ½ rails and placed on low with mats. The care plan wandited by the Nursing Administration Staff to ensith the plan of care had be updated to reflect the reside current status on 2/29/12. Oplan is current to resident's and is updated per MDS and Charge Nurse on an ongoin bases and as needed with ar orders, interventions, or charge interventions, or charge Nurse on an ongoin bases and as needed with ar orders, interventions, or charge Nurse on an ongoin bases and as needed with ar orders, interventions, or charge interventions or charge interventions can be completed for this resident.	nination w bed was ure en ent's Care status d/or g ny new unges.		
	Based on medical reand interview, the factor and interview, the factor asset (#41, #60, #18, #83, residents reviewed. The facility provided	T is not met as evidenced ecord review, observation, cility failed to conduct a essment on six residents #55, #57) of forty three a Credible Allegation of			(f) Resident # 57 A telephone order was received from the resident's physician for the use 1/2 side rails on 2/10/12. The resident was assessed on 2/20 using the Evaluation for use of Side Rails (for the evaluation	se of 0/12 of		
TUVI CIMS-256	7(02-99) Previous Versions C	Obsolete Event ID: 9D8D12		Facili	ty ID: TN6201 If conti	nuation sheet	Page 6 of 38	

04/02/2012 08:11

DEFARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY (F 272) Continued From page 5 side rail use) indicating the use of {F 272} least the following: 1/2 side rails by the Staffing Identification and demographic information; Coordinator. A Pre-Restraint Customary routine: Cognitive patterns; Assessment was completed on Communication; 2/21/12 by the Director of Vision: Mood and behavior patterns; Nursing that indicated side rails Psychosocial well-being; are used as a restraint. On 2/24/12 Physical functioning and structural problems; another Evaluation for the use of Continence: Disease diagnosis and health conditions; Side Rail was completed by the Dental and nutritional status; Staffing Coordinator indicating Skin conditions: the elimination of 1/2 side rails (no Activity pursuit: Medications: side rails are in place at this time). Special treatments and procedures; As of 2/24/12 the resident's Discharge potential; Documentation of summary information regarding current interventions include: the the additional assessment performed on the care locking of wheel chair prior to areas triggered by the completion of the Minimum transfer, offer rest periods, assist Data Set (MDS); and Documentation of participation in assessment. to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had This REQUIREMENT is not met as evidenced been updated to reflect the by: Based on medical record review, observation, resident's current status on and interview, the facility failed to conduct a 2/29/12. The care plan was comprehensive assessment on six residents audited by the Nursing (#41, #60, #18, #83, #55, #57) of forty three residents reviewed. Administration Staff to ensure that the plan of care had been The facility provided a Credible Allegation of updated to reflect the resident's FORM CMS-2567(02-99) Previous Varsions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2011 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING B. WING 445457 NAME OF PROVIDER OR SUPPLIER R 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION TAG DEFICIENCY) {F 272} Continued From page 5 current status on 2/29/12. The least the following: {F 272} Identification and demographic information; resident's care plan was reviewed Customary routine; by the Director of Nursing on Cognitive patterns: 3/7/12 and evaluated for fall Communication; Vision: prevention strategies and deemed Mood and behavior patterns; the intervention for constant Psychosocial well-being; Physical functioning and structural problems; supervision during toileting was Continence; inappropriate. After review of Disease diagnosis and health conditions; current interventions on 3/7/12 by Dental and nutritional status; Skin conditions; the Director of Nursing and Activity pursuit: further investigation of the Medications; leave unattended) it was Special treatments and procedures; Discharge potential; determined that the intervention Documentation of summary information regarding was implemented before a full the additional assessment performed on the care root cause analysis was conducted areas triggered by the completion of the Minimum Data Set (MDS); and (the intervention was removed as Documentation of participation in assessment. of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG program, participates in restorative with ambulation "walk to dine program", low bed with mats, This REQUIREMENT is not met as evidenced antiroll back brakes, the locking of wheel chair prior to transfer, offer Based on medical record review, observation, and interview, the facility failed to conduct a rest periods, assist to the bathroom comprehensive assessment on six-residents during rounds and as needed, further (#41, #60, #18, #83, #55, #57) of forty three monitoring and interventions will residents reviewed. continue to prevent falls. Resident's The facility provided a Credible Allegation of care plan is current and updated per MDS and/or Charge Nurse on FORM CMS-2567(02-99) Previous Vorsions Obsoleto Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND FLAN	NT.OF DEFICIENCIES OF CORRECTION	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MIII	TIPLE CONSTRUCTION	FOR	D. 03/14/2 M APPRO O. 0938-0
0		WENT WORK NUMBER:	A. BUILD	TIME CONSTRUCTION	(X3) DATE	SHRVEY
		445457	3		COMP	LETED
NAME OF	PROVIDER OR SUPPLIER	1448487	B. WING			R
	ENNESSEE HEALTH (- A	S	TREET ADDRESS AND	03/	12/2012
		CARE	1	TREET ADDRESS, CITY, STATE, ZIP CO 465 ISBILL RD	DE	28
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
TAG	REGULATORY OR A	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING MESONS	ID			
	- ON ON US	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RECTION	COMPLETI
/r				CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
{F 272}	Continued From pag	TP 5		- I TOICHCT)		
	least the following		{F 272}	an ongoing bases and as	t panda J	
	identification and do	mographic information;	,	The ally new orders		
	Customary routine;	and information;		interventions, or change		
1	Cognitive patterne:			or change	S.	
	Communication; Vision;			2. A review - c		-
[1]	Mood and hoher in	n#=		2. A review of all reside	nts	
			1	MDS's and Care Plans w	'as	
15	hysical functioning a	ng; nd structural problems;	1	mulated on 2/28/12 and		
16	Continence;	orracidial problems;	1	completed by 3/5/12 to a	n=1:c	
10	Disease diagnosis and Dental and nutritional	d health conditions:		other assessments that ma	entry	
15	KIN conditions	status;		have been coded or update	y not	
IA	Clivity pursuit	}		correctly for it	ed	
; IV	redications.	1	1	correctly for the use of sid	e	
2	pecial treatments and ischarge potential:	procedures		rails/restraints. Ten resider	ts were	
D	ischarge potential;	, sequies,		as needing obassis		
the	e additional appear	mary information regarding		a current or pro-	~ = 116	
alt	שמא [התחפרפת ה נו	ent performed on the care		assessment (MDS) for the uside rails all and	us	
l Va	tta Set (Mno)	The Minimum	1	side rails all and	ise of	
Do	cumentation of partic	ipation in assessment.		side rails, all of the ten were	e	
	98 G (875 307)	assessment.		completed between 2/28/12	and	
		1		- CY LIE WILL		
			1	Coordinator(s).		
			3	The Regional No.		
1			i	3. The Regional Nurse Consu	iltant	1
This	REQUIREMENT is	not met as evidenced	- 1	The state of the s	lator	
by:	ed on me	as evidenced	100	The Charles		
and	interview the	review, observation,		oordinator/Back Up MDS		l
- L.COI DI	Orehencive	anca to conduct a		obligator on 2/21/12 + 1		- 1
(#47)	#60-#18-#00-4-	ent-on six-residents	1 2/	22/12 on the completion of	1	- 1
resid	ents reviewed.	#0/) of forty three		assessmente and	.]	1
1			de	veloping/revision 6		
ine t	acility provided a Cre	dible Allegation of	to	veloping/revision of care pla	ıns	
2567(02-90) Previous Versions Obsolete	Admini 01	1	The resident's arm		
	revious Versions Obsolete	Event ID:9D8D12		dical condition. The MDS		1
			Facility ID:	TN(6204		

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN (T.OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY
			B. WING		R
NAME OF E	PROVIDER OR SUPPLIER	445457	O. WING_		03/12/2012
EAST TE	NNESSEE HEALTH C	100 100 100 100 100 100 100 100 100 100	4	REET ADDRESS, CITY, STATE, ZIP CODE 165 ISBILL RD MADISONVILLE, TN 37354	
(X4) ID PREFIX TAG	CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D BE CONDITION
a co	least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-be Physical functioning Continence; Disease diagnosis a Dental and nutritions Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and Documentation of pa	emographic information; patterns; eing; and structural problems; and health conditions; al status; and procedures; and procedures; and procedures; and procedures; and procedures; and procedures; and procedures; and procedures;	{F 272}	Coordinator will obtain a	olete f Side l led g with plan. ion raint d and straint eary of whilly for en. e an
				next scheduled assessment at	nd/or
RM CMS-2567	(02-99) Previous Versions Ob	solete Event ID-9D8D12			

Facility ID: TN6201

FRINTED: 03/14/2012 FORM APPROVED

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE	0. 0938-0: SURVEY LETED	
		445457	110	NG	- .	R	
NAME OF	PROVIDER OR SUPPLIER				03/	12/2012	
EAST T	ENNESSEE HEALTH	CARE		STREET ADDRESS, CITY, STATE, Z 465 ISBILL, RD	IP CODE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354			
PREFIX TAG	REGULATORY OR I	T MOST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		THE APPROPRIATE	(X5) COMPLET DATE	
{F 272}	Continued From pa	ige 5	/F a	as needed to assist	in developing	-	
	least the following:		{F 2	plan of care that me	or developing a		
	Customary routine;	emographic information;		resident's never 1	ets the		
1	Cognitive patterns:			resident's personal/ The MDS Coordina	medical goals.	1	
	Communication:			information preside	tor will utilize		
1	Vision; Mood and behavior			information provide	d in the	ļ	
	- SYCHOSOCIAI WAILL	Dina-		morning QA meetin	g, 24 hour		
	Physical functioning	and structural problems;		report, resident's me and communication	edical record,		
		and health conditions;		residents and/an C	from staff,		
1.0		al status		residents, and/or fan	illies when		
10	okin conditions:	,		completing resident	assessments		
l i	Activity pursuit; Medications;			to ensure accuracy. (On 2/23/12		
13	Special treatments a	nd procedures:		the Interim MDS Co	ordinator was		
1 -	Legital de polental.			in-serviced by the Re	gional Nurse		
		mmary information regarding ment performed on the care		Consultant on accura	cy when		
				completing MDS's a	nd the		
	Data Set (MDS); and	product of the Wildingm		development and rev	ision of care		
1	ocumentation of par	rticipation in assessment.		plans, along with rece	ent survey		
		İ		deficiencies. On 3/5/	12 the		
1		*		Regional Nurse Cons	ultant in-		
į				serviced the MDS Co	ordinator on		
				documenting (commu	nication)		
T	is REOLIDEMENT			changes made to the r	esident's		
		is not met as evidenced		plan of care on the 24	hour report.		
·B	ased on medical rec	cord review, observation,		1			
an co	u interview, the facil	ity failed to conduct a		4. The Interdisciplinar	y Team will		
—·+(#	11; #60, #18-#83-#	sment on six residents 55, #57) of forty three		review all completed I	MDSs and		
res	sidents reviewed.			——Care Plans for accurac	v. making		
Th	e facility provided	0 10		revisions as needed da	ilv		
	somy provided a	Credible Allegation of		(Monday-Friday) in th	e morning		
AS-2567(02	-99) Previous Versions Obse	Diete Event ID: 908D12		QA meeting. The Dire	ector or		

04/02/2012 08:11

4234424465 DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FRINTED: 03/14/20 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FORM APPROVE (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-039 (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION {F 272} Continued From page 5 DEFICIENCY DATE least the following: Assistant Director of Nursing will {F 272} Identification and demographic information; review MDSs and Care Plans to Customary routine; Cognitive patterns; ensure compliance is met for the Communication; next 90 days; then weekly for 90 Vision; days if compliance has been Mood and behavior patterns; Psychosocial well-being; maintained; then randomly Physical functioning and structural problems; thereafter. If at any point Continence; Disease diagnosis and health conditions; compliance is not met, the party Dental and nutritional status; will resume monitoring daily Skin conditions; (Monday-Friday) until Activity pursuit; Medications; compliance is maintained. The Special treatments and procedures; Director or Assistant Director of Discharge potential; Documentation of summary information regarding Nursing will review findings the additional assessment performed on the care related to the audits in the areas triggered by the completion of the Minimum quarterly QA Committee. Documentation of participation in assessment Completion Date: 3/22/12 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents -(#41, #60, #18, #83, #55, #57) of forty three residents reviewed. The facility provided a Credible Allegation of DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 908012

Facility ID: TN6201

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0301

	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7) estre-reaction	MULTIPLE CONSTRUCTION	(X3) DATE	0.0938-0 SURVEY ETED
		445457	B. WI	4G	R	
NAME O	F PROVIDER OR SUPPLIER				03/	12/2012
EAST	TENNESSEE HEALTH	CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATION	OULDAGE	COMPLE DATE
5 278} 2 SS=E A	Compliance on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted actions in 2012, removed the Non-compliance for citation (potential for The findings included Validation of the Crecompliance was accrecord review, review observation, and intenursing assistants, a facility provided evidentially provided evidences and provided for all resional when indicated evidence of in-service audits to ensure completed for all resional when indicated evidence of in-service audits to ensure completed include of the facility's corrective reviewed and evaluated committee. 183,20(g) - (j) ASSES: ACCURACY/COORDITE assessment must esident's status.	rch 5, 2012. A revisit th 12, 2012, revealed the mplemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level or more than minimal harm). ed: edible Allegation of complished through medical who of facility policy, erview with the nurses, and administrative staff. The ence Pre-Restraint hysical Restraint hysical Restraint hysical Restraint hysical Restraint hysical Restraint hysical assessments were dents, with removal of side. The facility provided a for all staff and random pliance. In out of compliance at a "E" an acceptable plan of continued monitoring to ractice does not recur and measure could be ad by the Quality Assurance SMENT NATION/CERTIFIED accurately reflect the	{F 278}		fied ——	
		st conduct or coordinate	1	SS=E		
CMS-2567((02-99) Previous Versions Obse	Diete Event ID: 9D8D12			1	

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W	NULTI	IPLE CONSTRUCTION	(X3) DATE S	
		445457	B. WI		-	024	R
EAST TE	PROVIDER OR SUPPLIER	ARE		4	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD MADISONVILLE, TN 37354	03/1	12/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PRÉF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	each assessment we participation of heal A registered nurse reassessment is completed individual who assessment must significant and that portion of the assessment must significant and knowing false statement in a subject to a civil more \$1,000 for each assessment in a subject to a civil more \$1,000 for each assessment willfully and knowing to certify a material aresident assessment. Clinical disagreement material and false statement and false statement in a subject to a civil more than the sessment. Clinical disagreement material and false statement in a sessessment. This REQUIREMENT by: Based on medical retained in the facility failed to en (MDS) was accurate #23) residents of forton the findings included Resident #41 was additional resident	with the appropriate th professionals. Inust sign and certify that the pleted. completes a portion of the gn and certify the accuracy of assessment. I Medicaid, an individual who ally certifies a material and resident assessment is ney penalty of not more than assessment; or an individual who ally causes another individual and false statement in a tries subject to a civil money than \$5,000 for each at does not constitute a latement. It is not met as evidenced accord review and interview, as sure the Minimum Data Set for four (#41, #53, #57 and y-three residents reviewed.	{F 2	778}	Requirements: The assessment must accurate reflect the resident's status. Individual who completes a profit of the assessment must sign a certify the accuracy of that put the assessment. Corrective Action Plan: 1. (a) Resident #41 was reasswith modifications made to the previous assessment on 2/28/the MDS Coordinator to include Dementia, Bipolar, Anxiety, Deep Vein Thrombosis diagnous (b) Resident #53 was reasses with modifications made to the previous assessment on 2/28/the MDS Coordinator to include Dysphagia. (c) Resident #57 was reasses with modifications made to a previous assessment on 2/29/the MDS Coordinator to include Dysphagia. (d) The resident #23 was discharged to the hospital or 1/2/12 and 1/2/12 an	Each portion and portion of ssessed he 12 by ude: and losses. ssed he 12 by ude: sed 12 by ude: sed 12 by ude: sed 12 by ude: sed 12 by ude: ssed he 12 by ude: ssed	
f	september 23, 2011, acility on October 24	and readmitted to the , 2011, with diagnoses Disease, Dementia, Bipolar,			1/3/12 and did not return to facility. His MDS assessment could not be corrected.	the	

PRINTED: 03/14/201. FORM APPROVE

STATEMEN	NT OF DEFICIENCIES	WE & MEDICAID SERVICES			OMB NO.	0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SU	JRVEY
		35	A. BUILDIN	IG	COMPLET	TED
		445457	B. WING _		02/40	
	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	03/12	2/2012
EAST T	ENNESSEE HEALTH	CARE	4	166 ISBILL RD		
				MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EVOU DELICIENC.	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	III D DE	(X5) COMPLETION DATE
{F 278}	Continued From pa	ane R		2. A review of all residents		
Tr can	Anxiety, Deep Vein	n Thrombosis and Colon	{F 278}	MDS's and Care Plans was	1	
	Cancer.	Traditional drid obtail		completed on 3/16/12 to ide		
	Medical record ray			other assessments that may		
	20, 2012, revealed	iew of the MDS dated January no documentation of the		have been coded accurately		
!	Dementia, Bipolar,	Anxiety and Deen Voin		corrections made as needed l		
	Thrombosis diagnos	ses.	1	MDS Coordinator(s). A revi		
	Interview with the N	IDS Coordinator on February		of all residents MDS's and C		
1	11, ZUIZ, 21 8 45 a 1	m in the MDC office				
1	committee the MDS	dated January 22 2040 July		Plans was initiated on 2/28/1	4 60 0 60 0 60 0 60 0 60 0 60 0 60 0 60	
1	Anxiety, and Deep V	noses of Dementia, Bipolar, Vein Thrombosis and the MDS		completed by 3/5/12 to ident		
	was not accurate.	Jent Fullorundaia gild file MD2		other assessments that may n		
1	Deeldent Hen			have been coded or updated		
1	October 23 2011 v	eadmitted to the facility on		correctly for the use of side		
	Whitesia, DASDUSSIS	vith diagnoses of Dementia, , Cardiovascular Accident and	1	rails/restraints. Ten residents		
	Left Frontal Hemator	ma.		identified as needing changes		
1.	Medical record route			made to a current or previous		
	Trovellibel 23. Mill	ew of physician consult dated		assessment (MDS) for the use		
•	"dysphasiathroat	problems"		side rails, all of the ten were		
1				completed between 2/28/12 a		
· C	nedical record review	w of the Minimum Data Set		3/5/12 by the MDS	na	
C	dated January 13, 20 documentation of the	J12, revealed no e diagnosis of Dysphagia.		Coordinator(s).		
li 1	nterview with the MC	OS Coordinator on February		2 0- 2/21/12 12/22/12 4	1	
, ,	1/1 40 14, at 0.45 a m	In the MDS office		3. On 2/21/12 and 2/22/12 the	3	
	Aumining the MDS 9:	dated January 13, 2012, did oses of Dysphasia, and the		Interim MDS Coordinator and	d the	
IV	MDS was not accurate	ises of Dysphasia, and the		Interdisciplinary team was in-		
				serviced by the Administrator	in	
T R	esident #57 was adr	mitted to the facility on		the presence of the Regional N	Nurse	
1	lovember 11, 2011, v	with diagnoses including		Consultant on accuracy when		

FORM CMS-2567(02-99) Provious Versions Obsolete

Dementia.

Alzheimer's Disease, Hypertension, and Senile

Event ID:9D8D12

Facility ID: TN6201

completing MDS's and the

development and revision of care plans, along with recent survey

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/201; STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 (X2) MULTIFLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER R 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY (F 278) Continued From page 9 deficiencies. The Regional Nurse (F 278) Consultant in-serviced the MDS Medical record review of the Minimum Data Set Coordinator and the Staffing (MDS) dated January 4, 2012, revealed "...severe cognitive impairment...independent for Coordinator/Back-Up MDS locomotion on and off the unit...side rails used Coordinator on 2/22/12 on the daily for restraints...chair to prevent rising...one completion of accurate assessments fall with injury..." since prior assessment dated and developing/revision of care October 12, 2011. Continued review of the MDS plans to reflect the resident's dated January 4, 2012, revealed there were no falls without injury. current medical condition. Medical record review of a Nurse's Event Note 4. The Director of Nursing dated November 22, 2011, revealed a fall with Services, or designee, will injury, and Nurse's Event Notes dated December conduct a random audit of three 10, 2011, and revealed a fall without injuries. (3) residents per week to ensure Interview on February 17, 2012, at 8:50 a.m., with that diagnoses, behaviors, and the MDS Coordinator, in the MDS office, falls are captured correctly for confirmed the MDS dated January 4, 2012, did four (4) consecutive weeks. These not reflect the fall the resident had experienced residents and their medical on December 10, 2011, and confirmed the MDS records will be assessed to ensure was not accurate. Resident #23 was admitted to the facility on that the MDS assessment is a true March 12, 2010, with diagnoses including reflection of the resident's status Dementia, Coronary Artery Disease, at the time of the assessment. Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, and Pernicious Findings of this audit will be discussed in the morning Quality Assurance meeting and the Medical record review of the Nursing Notes dated quarterly QA Committee until August 14, 2011, revealed "...refusing to put 02 such time consistent substantial on...cussing and yelling secondary to not being able to go on back porch..." compliance has been met. Medical record review of the Nursing Notes dated Completion date: 3/22/12 August 15, 2011, revealed "... Resident screaming 'nursey nursey'...Refused all 2000 (8:00 p.m.) meds (medications)..." FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN8201

PRINTED: 03/14/2012 FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T		OMB	NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	445457	B. WING			R
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH	CARE	465	ET ADDRESS, CITY, STATE, ZI SISBILL RD DISONVILLE, TN 37354	P CODE	3/12/2012
FINERIX LEAGH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
(F 278) Continued From pa	ige 10	{F 278}	-		
Medical record revi August 16, 2011, re to care givers"	ew of the Nursing Notes dated evealed "yelling out at times				
yell out frequently. staff. Drawing back	ew of the Nursing Notes dated vealed "Cont (continues) to When approached curses fist to strike at staffAwake out 'nurse' unable to				
Medical record revie August 18, 2011, rev 02"	ew of the Nursing Notes dated vealed "refusing to wear				
staff during care. Co thickened liquids-goi getting H2O (water)	w of the Nursing Notes dated realed "Resident cussing at ont (continues) to refuse ng to BR (bathroom) and Refusing to wear 02 when r). O2 sat (saturation) 90%			¥	
repeatedly removing	w of the Nursing Notes dated ealed the resident was 02 (oxygen); had increased (antianxiety medication) had thout effect.				
Medical record review (MDS) dated August resident exhibited no	v of the Minimum Data Set 20, 2011, revealed the behaviors.				
the MDS dated Augus	15, 2012, at 3:35 p.m., with the MDS office, confirmed at 20, 2011, did not reflect rs and confirmed the MDS			·	
CMS-2567(02-99) Previous Versions Ob	solete Event ID: 9D8D12	Facility ID:			

EAST TN HEALTH CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		445457	B. WIN	1G _		La December 2015	R 2/2012
	ROVIDER OR SUPPLIER	CARE		4	REET ADDRESS, CITY, STATE, ZIP CODE 165 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AR DEFICIENCY)	HÖULD BE	(X5) COMPLETION DATE
{F 280} \$\$=E	was not accurate. Refer to F221- Sub resident's right to b imposed for purpose convenience, and resident's medical's Refer to 272 - facilit comprehensive, accassessment of each functional capacity. Refer to F323 - Subfacility must ensure remains as free of a possible; and each supervision and assaccidents. 483.20(d)(3), 483.1 PARTICIPATE PLATE The resident has the incompetent or other incapacitated under participate in plannichanges in care and A comprehensive of	standard Quality of Care- e free from physical restraints ares of discipline or not required to treat the symptoms. Ity must make a curate, standardized in resident's need, and estandard Quality of Care- that the resident environment accident hazards as is resident receives adequate sistance devices to prevent O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or d treatment. are plan must be developed	{F 2				
	comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the res	he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's and periodically reviewed	¥				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2012 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING R NAME OF PROVIDER OR SUPPLIER 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PŘEFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 280} Continued From page 12 and revised by a team of qualified persons after (F 280) each assessment. F 280 483.20(d)(3) 483.10(k)(2) Right To Participate Planning Care-Revision This REQUIREMENT is not met as evidenced CP Based on medical record review, observation, SS=E and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three Requirement: residents reviewed. The resident has the right, unless The facility provided a Credible Allegation of adjudged incompetent or otherwise Compliance on March 5, 2012. A revisit found to be incapacitated under the conducted on March 12, 2012, revealed the corrective actions implemented on March 5, laws of the State, to participate in 2012, removed the Immediate Jeopardy. planning care and treatment of changes Non-compliance for F-221 continues at a "E" level in care and treatment. citation (potential for more than minimal harm). The findings included: Corrective Action Plan: Validation of the Credible Allegation of I. (a) Upon review of the Fall Risk Compliance was accomplished through medical Assessment on 2/6/12 completed record review, review of facility policy, by the licensed nurse the systematic observation, and interview with the nurses, nursing assistants, and administrative staff. The review of risk factors indicated a

FORM CMS-2567(02-99) Previous Versions Obsolete

facility provided evidence Care Plans were

reviewed and revised for all residents to reflect

evidence of in-service for all staff and random

The facility will remain out of compliance at a "E"

level until it provides an acceptable plan of correction to include continued monitoring to

audits to ensure compliance.

the residents current status. The facility provided

Event ID: 9D8D12

Facility ID: TN6201

risk score of 24 (high risk) for

factors from his Fall Risk

of side rails due to impaired

resident #41. Based on the risk

Assessment it was determined that

he was not a candidate for the use

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTEC: 03/14/201 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLJA AND PLAN OF CORRECTION OMB NO. 0938-039 (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 NAME OF PROVIDER OR SUPPLIER B. WING 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 280} Continued From page 12 judgment, incontinence, and history and revised by a team of qualified persons after {F 280} of falls from his bed. The side each assessment. rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the This REQUIREMENT is not met as evidenced resident's plan of care (removal of Based on medical record review, observation, side rails and low bed with one and interview the facility failed to evaluate and mat) to the direct caregivers on the update the Care Plan for seven residents (#41, Nurse Aide Communication #60, #18, #83, #52, #55 and #57) of forty three residents reviewed. Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone The facility provided a Credible Allegation of order was obtained by the charge Compliance on March 5, 2012. A revisit nurse and the Director of Nursing conducted on March 12, 2012, revealed the to discontinue the resident's bed corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. and chair alarm and use a sensor Non-compliance for F-221 continues at a "E" level pressure pad for his bed and chair. citation (potential for more than minimal harm). The resident remains on a low bed The findings included: with one mat at bedside after Validation of the Credible Allegation of receiving a telephone order from Compliance was accomplished through medical the physician on 2/23/12. The record review, review of facility policy, resident's care plan was updated on observation, and interview with the nurses, 2/24/12 by the Interim MDS nursing assistants, and administrative staff. The Coordinator to reflect the current facility provided evidence Care Plans were reviewed and revised for all residents to reflect orders and interventions (other the residents current status. The facility provided interventions: involve in activities, evidence of in-service for all staff and random slip resistant footwear, may place audits to ensure compliance. in the sight of staff when awake, rest periods as needed, family at The facility will remain out of compliance at a "E" level until it provides an acceptable plan of bedside sessions throughout the correction to include continued monitoring to day, get patient up when trying to get out of bed, offer snacks, attempt FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

56

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/201 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER FORM APPROVE OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A EUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B, WING R EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 280} Continued From page 12 to keep resident dry or clean and revised by a team of qualified persons after {F 280} immediately after incontinent each assessment. episode). The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated This REQUIREMENT is not met as evidenced to reflect the resident's current Based on medical record review, observation, status on 2/24/12. Resident was and interview the facility failed to evaluate and hospitalized from 2/24/12 to update the Care Plan for seven residents (#41, 3/2/12, returning with a change in #60, #18, #83, #52, #55 and #57) of forty three medical status. The Fall Risk residents reviewed. Assessment updated on 3/5/12 by The facility provided a Credible Allegation of the Director of Nursing reflects that Compliance on March 5, 2012. A revisit resident no longer attempts to self conducted on March 12, 2012, revealed the transfer, requiring assistance of 2 corrective actions implemented on March 5, for transfers. The resident no 2012, removed the Immediate Jeopardy. longer requires constant Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). supervision for the prevention of falls. He is on the FROG Program The findings included: that provides closer observation from various staff members. Validation of the Credible Allegation of Compliance was accomplished through medical Resident was transferred to the record review, review of facility policy, hospital again on 3/9/12 after visit observation, and interview with the nurses, by attending physician. MDS nursing assistants, and administrative staff. The Coordinator completed a discharge facility provided evidence Care Plans were assessment on 3/9/12. Resident reviewed and revised for all residents to reflect the residents current status. The facility provided was readmitted on 3/15/12 with evidence of in-service for all staff and random admitting Charge Nurse completing audits to ensure compliance. Fall Risk Assessment and Evaluation for the Use of Side The facility will remain out of compliance at a "E" Rails with the recommendation to level until it provides an acceptable plan of correction to include continued monitoring to FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:908012

Facility ID: TN6201

correction to include continued monitoring to

Event ID: 9D8D12

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/201; STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION OMB NO. 0938-039-(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER R 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) id Přefix TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE DEFICIENCY {F 280} Continued From page 12 be that side rails were not indicated and revised by a team of qualified persons after {F 280} at that time. Resident's care plan each assessment. was updated on 3/21/12 with a significant change assessment. Resident's care plan is updated per This REQUIREMENT is not met as evidenced MDS and/or Charge Nurse on ongoing bases and as needed with Based on medical record review, observation, any new orders, interventions, or and interview the facility failed to evaluate and changes. update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three (b) Resident #60's care plan has residents reviewed. een reviewed by the Interim The facility provided a Credible Allegation of ADS Coordinator and reflects the Compliance on March 5, 2012. A revisit resident's current status as of conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2/26/12. Resident was transferred 2012, removed the Immediate Jeopardy. to hospital on 2/26/12. The Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). Interim MDS Coordinator completed a Discharge The findings included: Assessment on 2/29/12 which Validation of the Credible Allegation of reflected the use of side rails as a Compliance was accomplished through medical restraint (as 1/2 rails were used record review, review of facility policy, observation, and interview with the nurses, until 2/23/12 during the 7 day nursing assistants, and administrative staff. The look back period). The resident facility provided evidence Care Plans were was reassessed upon return to the reviewed and revised for all residents to reflect the residents current status. The facility provided facility on 3/12/12 by the evidence of in-service for all staff and random admitting Charge Nurse who audits to ensure compliance. completed an Evaluation for the The facility will remain out of compliance at a "E" use of Side Rails and a Fall Risk level until it provides an acceptable plan of

Assessment with the

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTEL: 03/14/201 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVE OMB NO. 0938-039 (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 445457 NAME OF PROVIDER OR SUPPLIER B. WING EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X3) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 280} Continued From page 12 recommendation for no side rails and revised by a team of qualified persons after {F 280} indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment This REQUIREMENT is not met as evidenced was completed on 3/29/12). Based on medical record review, observation, Resident's care plan is updated and interview the facility failed to evaluate and per MDS and/or Charge Nurse on update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three an ongoing base and as needed residents reviewed. with any new orders, interventions, or changes. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the (c) Resident #18 The side rails corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. that were in place during the Non-compliance for F-221 continues at a "E" level survey were immediately changed citation (potential for more than minimal harm). to full anti-entrapment rails on The findings included: 2/6/12 by the Maintenance Director after receiving a Validation of the Credible Allegation of Compliance was accomplished through medical physician's order. The record review, review of facility policy, measurements for the bed zones observation, and interview with the nurses, were obtained by the Maintenance nursing assistants, and administrative staff. The facility provided evidence Care Plans were Director on 2/6/12 using a reviewed and revised for all residents to reflect standard tape measure with the residents current status. The facility provided evidence of in-service for all staff and random measurements. The Staffing audits to ensure compliance. Coordinator wrote a narrative note in the nurses notes on 2/6/12 The facility will remain out of compliance at a "E" level until it provides an acceptable plan of describing the resident with correction to include continued monitoring to limited functional status using the FORM CMS-2567(02-99) Previous Versions Obsolete side rails as a restraint. A Physical Event ID:9D8D12 Facility ID: TN6201 If continuation sheet Page 13 of 38

PRINTED: 03/14/2017 FORM APPROVED OMB NO 0938-0301

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB N	M APPROVE 0. 0938-03
AND A DAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE	SURVEY
		A. BUILDI		COMP	LETED
NAME OF PROVIDER OR SUPPLIER	445457	B. WING			R
EAST TENNESSEE HEALTH		\$7	REET ADDRESS, CITY, STATE, ZIP CO	DE 03/	12/2012
			MADISONVILLE, TN 37354		
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF COM		
		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	Ct 101 11	COMPLETION DATE
(F 280) Continued From pa	ge 12		Restraint Assessment was		-
and revised by a te	am of qualified persons after	(F 280)	updated on 2/6/12 by the	Staffing	
each assessment.	posterio diter		Coordinator for the use of	side	
			rails. A Side Rail Assessn	nent	
			and Informed Consent was	e cianod	
This REQUIREMEN	T :		by the family on 2/13/12.	o eiRiteti	
	IT is not met as evidenced		2/20/12 the MDS Coordina	J11	
Based on medical r	ecord review, observation,		completed an Evaluation for	11() <u>F</u>	
			of Side Rails with a reduct	or use	
#60, #18, #83 #52	n for seven residents (#41, #55 and #57) of forty three		side rails from full (anti-	ion in	
residents reviewed.	or and #57) of forty three		entranment) to 1/		
The facility provided	- 0 - 171	į	entrapment) to ½ rails, the	_	
	a Credible Allegation of	1	physician was notified and	order	
			was obtained for ½ rails. The	ne	
2012, removed the In			measurements for the bed z	ones	y
			were obtained by the Maint	enance	
citation (potential for r	nore than minimal harm).		Director on 2/20/12. On 2/	23/12	
The findings included:		j	the resident was evaluated a	gain	
	1		for side rail reduction by the	2	
Validation of the Credi	ble Allegation of	1 3	Staffing Coordinator, the		1
record review review	mplished through medical	1	resident's side rails was		
observation and inter-	or lacility policy,	1 5	eliminated and the resident	was	
nursing assistants, and	d administrative staff. The	1	placed on a low bed with ma	its.	
reviewed and revised for	or all are Plans were	1 1	The Physical Restraint		
the residents current of	or all residents to reflect	1 4	Assessment was completed of	oig I	ł
evidence of in-service f audits to ensure compli	or all staff and random	2	728/12 by the Staffing		
	ance.	C	coordinator for the elimination	on of	
The facility will remain o	out of compliance at a "E"		ide rails and the use of a low	hed -	
level until it provides an	acceptable plan of	W	1th mats after receiving a		
	nunuea monitoring to	pl	hysician's order. The care	olan	
C OFFICE A			The care	hram	
S-2567(02-99) Previous Versions Obsol	ete Event ID: 9D8D12	l W	as audited by the Nursing	1	*

4234424465

EAST TN HEALTH CARE PAGE 63/99

DEI CEI	PARTMENT OF HEALTI	HAND HUMAN SERVICES			PRINTE	D: 03/14/201
STATE AND P	MENT OF DEFICIENCIES LAN OF CORRECTION	MEDICAID SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO	M APPROVEI <u>0. 0938-039</u> SURVEY
NAME	OF PROVIDER OR SUPPLIER	445457	A. BUILD B. WING			R
1	T TENNESSEE HEALTH	CARE		TREET ADDRESS, CITY, STATE, ZIP COI 465 ISBILL RD	03/ DE	12/2012
(X4) PRE	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CHOINDE	(X5) COMPLETION DATE
	and revised by a tea each assessment. This REQUIREMEN' by: Based on medical reand interview the facility provided at Compliance on March conducted on March corrective actions imp 2012, removed the Im Non-compliance for Ficitation (potential for march findings included: Validation of the Credit Compliance was accorrective actions, and intervinursing assistants, and facility provided evidence reviewed and revised for the residents current state evidence of in-service for audits to ensure compliance.	in of qualified persons after It is not met as evidenced accord review, observation, lity failed to evaluate and for seven residents (#41, 55 and #57) of forty three Credible Allegation of 5, 2012. A revisit 12, 2012. revealed the lemented on March 5, mediate Jeopardy. 221 continues at a "E" level for than minimal harm). Die Allegation of inplished through medical of facility policy, ew with the nurses, administrative staff. The ce Care Plans were in all residents to reflect atus. The facility provided or all staff and random ance.	s i: a		dent's On Of bed Opper Ock Oppor Owel Ormine Oram. Offict	
	The facility will remain o level until it provides an correction to include con	ut of compliance at a "E"		nivosugation of fall on	'	

correction to include continued monitoring to

PRINTED: 03/14/2012 FORM APPROVED

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	OVOLATILE). 0938-03 <u>9</u>
AND PLAN (OF CORRECTION	ECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		445457	B. WING			R
	PROVIDER OR SUPPLIER ENNESSEE HEALTH (CARE	1 .	REET ADDRESS, CITY, STATE, ZIP		12/2012
(X4) ID PREFIX	(POPIT DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CALL	ORRECTION	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLÉTION
{F 280}	Tom page 12		{F 280}			
	each assessment.	am of qualified persons after		rolled from the bed in l		
				bed was in lowest posi- mats on both sides, no		
				noted, intervention to a		
	This REQUIREMEN by:	T is not met as evidenced		noodles to define perin		
	Based on medical r	ecord review, observation,		bed with all above inte		E 8
	and interview the fac	cility failed to evaluate and n for seven residents (#41,		added to the care plan		
1.7	#00, #10, #03, #52.	#55 and #57) of forty three		implemented. Residen		
	residents reviewed.	· · · · · · · · · · · · · · · · · · ·		plan is updated per MC Charge Nurse on an on		
	The facility provided	a Credible Allegation of	i	bases and as needed wi		
	compliance on March conducted on March corrective actions im	th 5, 2012. A revisit 12, 2012, revealed the		orders, interventions, o		
1	Non-compliance for I	mmediate Jeopardy.		(d) Resident #83's car		
10	ortation (potential for	more than minimal harm).		reviewed and modified		**
T	The findings included	l:		Interim MDS Coordina		
V	/alidation of the Cred	tible Allegation of		reflects the resident's c status as of 2/29/12. Or		
10	compliance was according	implished through modical		an Evaluation for the u		
10	ecord review, review bservation, and inter	View with the nurses	1	Rails and Physical Res		
1.11	arang assistants, ar	10 administrative state TL-		Assessment was compl	,	
1.0	- Ale Men alid tenised	nce Care Plans were for all residents to reflect		Director of Nursing inc		
	ie residents current	Status. The facility provided		elimination of ½ rails a	nd placed	
	vidence of in-service for all staff and random udits to ensure compliance.			on low bed with mats.		
		out of compliance at a "E"		plan was audited by the		
1 - 4	or writing broyides a	D acceptable plan of		Administration Staff to		
CO	rection to include continued monitoring to			that the plan of care had updated to reflect the re		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES PRINTED: 03/14/20 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER FORM APPROVI (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-03 A EUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG (F 280) Continued From page 12 DEFICIENCY) DATE and revised by a team of qualified persons after (F 280) current status on 2/29/12. Care each assessment. plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing This REQUIREMENT is not met as evidenced bases and as needed with any new orders, interventions, or changes. Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three (e) Resident #52's care plan was reviewed and modified by the The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit Interim MDS Coordinator and conducted on March 12, 2012, revealed the reflects the resident's current corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. status as of 2/29/12. Care plan is Non-compliance for F-221 continues at a "E" level current to resident's status and is citation (potential for more than minimal harm). updated per MDS and/or Charge The findings included: Nurse on an ongoing bases and as Validation of the Credible Allegation of needed with any new orders, Compliance was accomplished through medical interventions, or changes. record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The (f). Resident # 55's care plan was facility provided evidence Care Plans were reviewed and modified (the reviewed and revised for all residents to reflect removal of placing at the nursing the residents current status. The facility provided station, the following interventions evidence of in-service for all staff and random audits to ensure compliance. remained in effect as of 2/14/12: assist with transfers as needed, The facility will remain out of compliance at a "E" FROG program, geri chair when level until it provides an acceptable plan of out of bed) on 2/14/12 by the MDS correction to include continued monitoring to Coordinator and reflected the DRM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			r-Ur	:D: 03/1
ľ	9859203 75 53	IDENTIFICATION NUMBER		JI. TIPLE CONSTRUCTION	- OMB V	O. 0938
			A. BUIL	DING	(X3) DATE	SURVEY
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING			
EAST	- LIN ON SUPPLIER				03	R
	ENNESSEE HEALTH	CARE	Is	TREET ADDRESS, CITY, STATE, ZIP C	ODE US	12/2012
(X4) ID	SIMMARADIA			TO IOMICE KD	10.11.110	
PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID	MADISONVILLE, TN 37354		
	MEGOLATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CO	PRRECTION	T
			TAG	CROSS-REFERENCED TO THE	N SHOULD BE	COMPLE
{F 280}	Continued From pag			Jan Joight (1)		DAT
	and revised by a tax	Je 12	{F 280}	resident's current status	The	
	each assessment	m of qualified persons after	(1 200)	LUSICELL'S Threigh state		l
. 1				1 24/12 and the ron	i -1	1
				ACTION ICUMITED COROTONAL		
				Supervision, No further of		
1-	This REQUIREMENT	F :		Jaio Diali lingares con	al L .	
t	DA:	is not met as evidenced		completed due to the reci	dent	
1 9	based on modia-1			expiring on 2/16/12.	ALCHE .	
a	nd interview the facil	ity failed to evaluate				
#	and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, residents reviewed.			(g) Resident # 57 A telep	nhone	
re				order was received from t	ha	
1				resident's physician for th	me	
TI	ne facility provided a	Credible Allegation of		½ side rails on 2/10/12. T	e use of	
CO	ompliance on March inducted on March 1	5, 2012. A revisit		resident was	he	
CO	rrective setime	5, 2012. A revisit 2, 2012, revealed the		resident was assessed on 2	/20/12	
120	12. removed the r	March 5		using the Evaluation for us	se of	
INO	N-Compliance to ma	rediate Jeopardy.	1	Side Rails (for the evaluation	on of	
Cita	ation (potential for mo	221 continues at a "E" level ore than minimal harm).	1	side fall use) indicating the	1100 - 5	
The	finding :	and minimal narm).		72 Side rails by the Staffing	1	100
1	findings included:	1	- 1	Coordinator, A Pre-Restrai		
Vali	dation of the Credible	0.40		Assessment was	nt	
Con	npliance was accomi	e Allegation of polished through medical facility policy.		Assessment was completed	on	
oher	ord review, review of ervation, and intention	facility policy		2/21/12 by the Director of	1	
nurs	ervation, and intervieuing assistants, and a	w with the nurses		Nursing that indicated side	rails	
facili	ty provided	diffilistrative staff Tha	1 '	are used as a restraint On 2	/24/12	
I LEVIE	Wed and route have	Tails were	1 6	mother Evaluation for the "	50 -£	
the re	esidente our	all residents to reflect	5	Side Rail was completed by	oc 01	
evide	nce of in conde	THE TACHITY Drovided	S	Staffing Coordinator indicate	the	
-+	s to ensure complian	ce.	t}	re elimination indicat	ing	
The fa	acility will		·	ne elimination of ½ side rail	s (no	
level (until it provides an action to include contin	of compliance at a "E"	7 31	ue falls are in place of this	ime).	
correc	ction to include contir	ceptable plan of	1 41	of 2/24/12 the resident's	T 90 W	
	- 0011(1)	rued monitoring to	cu	litent interventions included	41	
-2567(02-99)	Previous Versions Obsolete	Event ID: 908D12	_ lo	cking of wheel chair prior t	ine	1
		hyper to anne		vi Chair prior t	n 1	86

The facility will remain out of compliance at a "E"

Event ID: 9D8D12

level until it provides an acceptable plan of correction to include continued monitoring to

FORM CMS-2567(02-99) Previous Versions Obsolete

04/02/2012 08:11 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2011 STATEMENT OF DEFICIENCIES FORM APPROVEL (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AND PLAN OF CORRECTION OMB NO. 0938-039. (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER R 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE DEFICIENCY {F 280} | Continued From page 12 transfer, offer rest periods, assist and revised by a team of qualified persons after {F 280} each assessment. to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the This REQUIREMENT is not met as evidenced Nursing Administration Staff to Based on medical record review, observation, ensure that the plan of care had and interview the facility failed to evaluate and been updated to reflect the update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three resident's current status on residents reviewed. 2/29/12. The care plan was audited by the Nursing The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit Administration Staff (Director of conducted on March 12, 2012, revealed the Nursing, Staffing Coordinator, corrective actions implemented on March 5, and MDS Coordinator) to ensure 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level that the plan of care had been citation (potential for more than minimal harm). updated to reflect the resident's The findings included: current status on 2/29/12. The resident's care plan was reviewed Validation of the Credible Allegation of Compliance was accomplished through medical by the Director of Nursing on record review, review of facility policy, 3/7/12 and evaluated for fall observation, and interview with the nurses, prevention strategies and deemed nursing assistants, and administrative staff. The facility provided evidence Care Plans were the intervention for constant reviewed and revised for all residents to reflect supervision during toileting the residents current status. The facility provided assessments that may not have evidence of in-service for all staff and random audits to ensure compliance. been coded or updated correctly

If continuation sheet Page 13 of 38

for the was inappropriate. After

Facility ID: TN6201

review of current interventions on

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	H AND HUMAN SERVICES E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	OMB	ED: 03/1. RM APPR IO: 0938
<u> </u>	a production that women is		^ BUILD	DING	(X3) DATE	SHOWEN
NAME OF	F PROVIDER OR SUPPLIER	445457	B. WING		COM	PLETED
EAST	TENNESSE				00	R
	TENNESSEE HEALTH (CARE	l s	TREET ADDRESS, CITY, STATE, ZIP CODE	103	12/2012
(X4) ID	SUMMARY STA					
PREFIX TAG	REGULATORY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING DEPORT	· I ID	MADISONVILLE, TN 37354		
	OKTORIS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION	TION	
(= 0			TAG	CROSS-REFERENCED TO THE ARREST	ULD BE	COMPLE
{F 280}	The Firm page	0.13	1	DEFICIENCY	OPRIATE	DATE
	and revised by a tear	e 12 n of qualified persons after	{F 280}	3/7/12 by the Director of Nu		
	each assessment.	ir of qualified persons after	1, 500}	and further in the Director of Nu	rsing	
			1	and further investigation of the	he	
- 1			1	With infervention	ot to	
1		i i		reave unattended) it rive-		
	This REQUIREMENT	is not		determined that the intervent		
1	Dy:	is not met as evidenced	1	multiplemented before a ful	, 1	
	Pasen on marri	1		Tool cause analysis was and		
, , ,	Based on medical record review, observation, and interview the facility failed to evaluate and #60, #18, #83, #52, #55 and #57) of forty three			(the intervention was removed	cted	
#				of 2/24/12 into	as	
re	esidents reviewed.	and #57) of forty three		of 2/24/12 interventions above).	
- 1	The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit			5 5/42/12. Clitrent int-	1.0	
C				ostucill remains on the Enco	3	
100				Program, Darlicinates in	a	
) CQ	Trective notion	2014 levesled the		"typil to J		
140	IZ Temovadu .	THE WORLD IN MARCH E		program", low bed with mate	- 1	
1110	D-Compliant -	Soldie Jeobardy	1 3	antiroll back brakes 41	_	33
Orte	etion (potential for mor	21 continues at a "E" level te than minimal harm).				
The	e findings included:	mann),				
					.	
Con	idation of the Credible	Allegation	n	nonitoring and interventions will	r	
reco	inpliance was accompl	ished through many	c	ontinue to prevent a transmitted		
1 2000	Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The reviewed according to the control of			ontinue to prevent falls. Care plan		1
1 nurs						- 1
lacin	IV Drovida	I I I SIFATIVA eta# TI	₽ 1 92	Factor Dec Willie		- 1
1 . 4110	WELL DOM ****	- GIIS WAFA	1	6 I VUISE On an and		1
1 -4100	TILE OF IN A	· · · · · · · · · · · · · · · · · · ·	1 -	and as needed with		
audits	ince of in-service for a to ensure compliance	Il staff and random	ord	lers, interventions, or changes.		1
		T- 1		o, or changes,		1
	acility will remain out o	f oan				
The fa	Intil it provid	compliance at a "E"				1
The fa	tian it provides an acco		1			
The fallevel u	worr to include continu	ed monitoring	ł			
The fallevel u	worr to include continu	ed monitoring to				
The fallevel u	tion to include continu	ed monitoring to Event ID: 9D8D12	Facility ID: TN			

AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	H AND HUMAN SERVICES RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				rur	ED: 03/1 RM APPR
		IDENTIFICATION NUMBER:	l (x	2) MU	LTIPLE CONSTRUCTION	OIMB V	O.0938
		44545-	1	BUILE	<u> </u>	COME	SURVEY LETED
NAME OF	PROVIDER OR SUPPLIER	445457	B.	WING			R
EASTT	ENNESSEE HEALTH	CARE		s	TREET ADDRESS OF	03,	12/2012
(X4) ID					TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD		2000
PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		\perp	MADISONVILLE, TN 37354		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		D FIX	PROMOTERIE DI		(m)
			TA		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE ARREST	DULD BE	COMPLE
{F 280}	Continued E	_			CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DAY
	Continued From pag	ge 12	(7)				
1	each assessment	m of qualified persons after	1 11-2	280}	all residents		
	- reoment,	- 11(0)			MDS's and Care Plans was		
1			1		initiated on 2/28/12 and		
1			1		completed by 3/5/12 to identif		
-	This REQUIREMENT	10 4-1			other use of side rails/restraint	У	
Ł	Dy:	is not met as evidenced			Ten residente	S.	
1 1	Dasen on modi-			1	Ten residents were identified a	ıs	
u	Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, residents reviewed.				needing changes made to a	1	
#					current or previous assessment		
∫r∈					(MDS) for the use of side rails	all	
- 9	The facility provide			- 1	or the ten were completed		
Co	The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).				between 2/28/12 and 3/5/12. T	ha	
CO				10	care plans were audited by the	ine	
100				1	Nursing Administration Staff fo	_ 1	
No				ı	residents: #41, 60, 18, 83, 52, 5	or	
cita				2	and 57 to ensure that the plan of	5,	
1				0	are had have and the plan of	f	
The	findings included:			f1	are had been updated to reflect		
			1.5	2	he resident's current status on		
Con	lidation of the Credible Allegation of mpliance was accomplished through medical cord review, review of facility policy.			2	/29/12. On 3/5/12 the Regiona	1	
reco	rd review	holied infough medical	j	14	urse Consultant in-serviced the		
1 0056	LYALIOD ODA	Tollidy Policy.		IV.	LDS Coordinator on	1	
/aciii	servation, and interview with the nurses, rsing assistants, and administrative staff. The liewed and revised for all residents to reflect dence of in-service for all staff and random			do	ocumenting (communication)		
I I CALG				ch	anges made to the resident's		
me re				pl:	an of care on the 24 hour report	.	
1 evide				Th	e Nurse Aide Communication		
S		· · ·	1	Sh	eet will also be an intermediation		
The fa	acility will			_the	eet will also be updated when		
level u	intil it provides an actition to include contin	of compliance at a "E"		አለን	plan of care changes by the	·	
Lorrer	tion to include contin	Ued monitoring	1	1411	OS Coordinator(s).		
		· · · · · · · · · · · · · · · · · ·	I I				- 1
	Province						1
777	Previous Versions Obsolete	Event ID:9D8D12	Facility	_			.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PRINTED: 03/14/2 (X1) PROVIDER/SUPPLIER/CLIA FORM APPRO IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0 A. BUILDING (X3) DATE SURVEY NAME OF PROVIDER OR SUPPLIER COMPLETED 445457 B. WING EAST TENNESSEE HEALTH CARE R STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX MADISONVILLE, TN 37354 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETIO {F 280} / Continued From page 12 DEFICIENCY DATE and revised by a team of qualified persons after {F 280} 3. The Regional Nurse Consultant in-serviced the MDS Coordinator and the Staffing Coordinator/Back Up MDS This REQUIREMENT is not met as evidenced Coordinator on 2/21/12 and 2/22/12 on the completion of Based on medical record review, observation, accurate assessments and and interview the facility failed to evaluate and developing/revision of care plans update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three to reflect the resident's current medical condition. Resident and families will be notified of The facility provided a Credible Allegation of scheduled care plan meetings by Compliance on March 5, 2012. A revisit the MDS Coordinator prior to the conducted on March 12, 2012, revealed the residents next scheduled corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. assessment and/or as needed to Non-compliance for F-221 continues at a "E" level assist in developing a plan of care citation (potential for more than minimal harm). that meets the resident's personal/medical goals. The MDS The findings included: Coordinator will utilize Validation of the Credible Allegation of information provided in the Compliance was accomplished through medical morning Quality Assurance record review, review of facility policy, meeting, 24 hour report, observation, and interview with the nurses, resident's medical record, and nursing assistants, and administrative staff. The facility provided evidence Care Plans were communication from staff, reviewed and revised for all residents to reflect residents, and/or families when the residents current status. The facility provided completing resident assessments evidence of in-service for all staff and random to ensure accuracy. On 2/23/12 audits to ensure compliance. the Interim MDS Coordinator was The facility will remain out of compliance at a "E" inserviced on accuracy when level until it provides an acceptable plan of completing MDS's and the correction to include continued monitoring to development and revision of care plans, along with recent survey RM CMS-2567(02-99) Previous Versions Obsoleté deficiencies. Event ID:908012

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PRINTED: 03/14 FORM APPRO (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-1 A. GUILDING (X3) DATE SURVEY NAME OF PROVIDER OR SUPPLIER 445457 COMPLETED B. WING EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL MADISONVILLE, TN 37354 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE {F 280} Continued From page 12 COMPLETIC DEFICIENCY and revised by a team of qualified persons after DATE each assessment. {F 280} 4. The Interdisciplinary Team(Administrator, Director of Nursing, and Assistant Director of Nursing, Maintenance Supervisor, This REQUIREMENT is not met as evidenced Social Services/Admissions Based on medical record review, observation, Director, MDS Coordinator, Food and interview the facility failed to evaluate and Service Supervisor, and Activity update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three Director) will review all completed MDSs and Care Plans for accuracy, making revisions as The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit needed daily (Monday-Friday) in conducted on March 12, 2012, revealed the the morning QA meeting. The corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Director or Assistant Director of Non-compliance for F-221 continues at a "E" level Nursing will review MDSs and citation (potential for more than minimal harm). Care Plans to ensure compliance The findings included: is met for the next 90 days; then weekly for 90 days if compliance Validation of the Credible Allegation of Compliance was accomplished through medical has been maintained; then record review, review of facility policy. randomly thereafter. If at any observation, and interview with the nurses, point compliance is not met, the nursing assistants, and administrative staff. The facility provided evidence Care Plans were party will resume monitoring reviewed and revised for all residents to reflect daily (Monday-Friday) until the residents current status. The facility provided compliance is maintained. The evidence of in-service for all staff and random audits to ensure compliance. Director or Assistant Director of Nursing will review findings The facility will remain out of compliance at a "E" level until it provides an acceptable plan of related to the audits in the correction to include continued monitoring to quarterly QA Committee. VM CMS-2567(02-99) Previous Versions Obsolete Completion date: 3/22/12 Event ID: 9D8D12 Facility.ID: TN6201 If continuation sheet Page 13 of 38

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DEFICIENCY) {F 280} Continued From page 13 F 281 (F 280) ensure the deficient practice does not recur and the facility's corrective measure could be 483.20(k)(3)(i) Services Provided reviewed and evaluated by the Quality Assurance Meet Professional Standards Committee. 483.20(k)(3)(i) SERVICES PROVIDED MEET {F 281} SS=D PROFESSIONAL STANDARDS (F 281) SS=D The services provided or arranged by the facility Requirement: must meet professional standards of quality. The services provided or arranged by the facility must meet professional This REQUIREMENT is not met as evidenced standard of quality. by: Based on medical record review, and interview, the facility failed to follow physician's orders for Corrective Action Plan: one resident (#55) of forty-three residents reviewed. Resident #55 received medications as ordered by the physician The findings included: beginning 2/16/12. Resident #55 was admitted to the facility on July 2. The Nursing Administration team 9, 2008, with diagnoses including Brain audited the Medication Records for Syndrome with Presentle Brain Disease, Hypertension, Psychotic Mood Disorder, and all residents completed on 3/19/12 to ensure residents were getting Osteoarthrosis. medications as ordered by the Medical record review of the Physician's physician. All resident's MARs were Recapitulation Orders dated January 1, 2012, found to be in compliance for through January 31, 2012, revealed "... Clonidine receiving medications as ordered. (blood pressure medication) 0.1 mg (milligram) one tab (tablet) two times daily-hold if systolic 3. All licensed nursing staff were in-(blood pressure) lower than 130..." serviced by the Director of Nursing on 2/17/12, 2/29/12, and 3/15/12 on Medical record review of the Medication following physician orders when Administration Record dated January 1, 2012 through January 18, 2012, revealed Clonidine 0.1 administering medications.

FORM CMS-2567(02-99) Previous Versions Obsolete

mg was initialed as administered Janaury 1, 2012, through January 18, 2012 at 8:00 a.m. and

Event ID: 9D8D12

Facility ID: TN6201

PRINTED: 03/14/2012 FORM APPROVED

ND PLAN OF CORRECTION	445457		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
					Ŗ
NAME OF PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP COI 65 ISBILL RD IADISONVILLE, TN 37354		12/2012
COLUMN CO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLE DATE
obtained on the every 2012-120/40, January 2012-122/70, January 10, 2012-120/70, January 12, 2012-12012-118/60, January 17, 2012-119/55, and Interview with the Diffebruary 16, 2012, adining room, confirm were not followed by when the systolic block 130. 318} SS=D IN RANGE OF MOT Based on the compressident, the facility in with a limited range of appropriate treatment range of motion and/decrease in range of This REQUIREMENT by: Based on medical remainded interview the facility in the systolic block 130.	ew of the nursing notes ng blood pressure reading ening shift: January 1, ary 3, 2012-128/54, January 4, ary 6, 2012-126/68, January 7, ary 9, 2012 no b/p, January 11, 2012-104/54, 15/60, January 14, ary 16, 2012-102/62, January 16, 2012-102/62, January 17, 2012-118/65. Trector of Nursing (DON) on at 8:25 a.m. in the small led the Physician's Orders administering the Clonidine administering the Clonidine administering the Clonidine and pressure was lower than ASE/PREVENT DECREASE ION The properties to increase the present of the prevent first to increase are the prevent first to increase are the prevent first to increase are the prevent first to the	{F 318}	4. The Director of Nursing (DNS), or designee, will crandom audits of six (6) M Records to verify that med are administered as ordered (6) consecutive weeks to excompliance is maintained. Medication Audit findings discussed in morning QA mand quarterly QA Committee Completion date: 3/22/12	omplete dedication ications I for six asure will be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES - Crimo PRINTED NO 1872012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B, WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL di PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (F 281) Continued From page 14 {F 281} 8:00 p.m. Medical record review of the nursing notes revealed the following blood pressure reading obtained on the evening shift: January 1, 2012-120/40, January 3, 2012-128/54, January 4, 2012-122/70, January 6, 2012-126/68, January 7, 2012-124/72, January 9, 2012 no b/p , January 10, 2012- 120/70, January 11, 2012- 104/54, January 12, 2012-115/60, January 14, 2012-118/60, January 16, 2012-102/62, January 17, 2012-119/55, and January 18, 2012-118/65. Interview with the Director of Nursing (DON) on February 16, 2012, at 8:25 a.m. in the small dining room, confirmed the Physician's Orders were not followed by administering the Clonidine when the systolic blood pressure was lower than 130. 483.25(e)(2) INCREASE/PREVENT DECREASE (F 318) {F 318} IN RANGE OF MOTION SS=D F318 Based on the comprehensive assessment of a 483.25(e)(2) Increase/Prevent resident, the facility must ensure that a resident with a limited range of motion receives Decrease In Range of Motion appropriate treatment and services to increase range of motion and/or to prevent further SS=D decrease in range of motion. Requirement: This REQUIREMENT is not met as evidenced Base on the comprehensive by: assessment of a resident the Based on medical record review, observation, and interview the facility failed to prevent a facility must ensure that a resident decrease in Range of Motion for one resident with a limited range of motion (#52) reviewed for Range of Motion of forty three receives appropriate treatment and residents. services to increase range of FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: 9D8D12

FRINTED: 03/14/201 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION m (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 318} Continued From page 15 {F 318} motion and/or to prevent further The findings included: decrease in range of motion. Resident #52 was admitted to the facility on June Corrective Action Plan: 1, 2006, with diagnoses including Dementia, Mood Disorder, Depression, and Renal 1. The MDS Coordinator completed Insufficiency. a significant change assessment Medical record review of the Minimum Data Set with Assessment Reference Date (MDS) dated December 7, 2011, revealed of 2/23/12 to reflect resident ...moderately impaired for decision #52's current status. Therapy making...required extensive assist for bed mobility...no impairment in upper evaluated the resident on 2/28/12 extremities...chair to prevent rising...bed rails with a plan for Restorative used daily for restraint..." Nursing to treat for ROM. Medical record review of a Physician Telephone The Nursing Administration team Order dated December 2, 2011, revealed "...may use arm sling to keep arm on lap table to prevent audited residents for a change in injury..." range of motion, through random rounds completed on 3/17/12 with Medical record review of the Interdisciplinary Plan no new residents identified has of Care last reviewed December 7, 2011, having a change in their ROM. revealed "...may use arm immobilizer to help support R (right) arm on lap tray (to prevent

right arm secured to the chest with a Velcro strap

FORM CMS-2567(02-99) Previous Versions Obsolete

support..."

injury)...lap table on W/C (wheel chair)...keep R

Physician Recapitulation Orders revealed "...lap tray while up in W/C...may use sling to help

Observation on February 8, 2012, at 12:50 p.m., on the 200 hallway, revealed the resident in a wheelchair, the lap tray in place, the shoulder immobilizer around the resident's chest and the

Medical record review of the February 2012

arm on lap table when in W/C...

Event ID: 9D8D12

Facility ID: TN6201

3.Staff was in-serviced by the

Administrator and/or Director of Nursing on 2/17/12, 2/27/12,

2/29/12, and 3/15/12 on changes

in resident status, not limited to:

decrease in ROM, ambulation,

and ADL's.

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SE

FRINTED: 03/14/2012 ΞD 91

STATEME!	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) A	MULTIPLE CONSTRU	ICTION	OMB NO	0. 0938-03
		IDENTIFICATION NUMBER:		ILDING	oc non	(X3) DATE COMPI	SURVEY LETED
		445457	8, WII	VG			R
	PROVIDER OR SUPPLIER		<u> </u>	STREET ABORES		03/	12/2012
EAST T	ENNESSEE HEALTH	CARE		465 ISBILL RD			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	Ţ <u>-</u> J		LE, TN 37354		
PREFIX TAG	CONTRACTOR DEFICIENT.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	A (EACH	OVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	OUR DOC	COMPLETE DATE
{F 318}	Continued From pa	age 16					
	on the immobilizer.		{F 31	^[8] 4.The DO	N or designee will		
		2		monitor	for compliance thro	nnoh	
	Observation on Fel	oruary 9, 2012, at 3:45 p.m., in		random	round audits for six	(6)	
	, and more lobby. Teve	HIPO IDO POCIDANT IN +		weeks, re	eferring residents	(0)	i
	wheelchair the lan	to the right side of the tray in place, the shoulder	20	demonstr	rating a decline in F	MO	
	municounzet tiot il fi	Se and the right arm hanning to		to the the	erapy department fo	COTAL	
	Over the null ann n	est of the whoolohain		screening	2.	'A.	1
in I	extending toward th	e floor (no immobilizer).			2		
		. 1		Complet	ion date: 3/22/12		
	the front lobby rove	ruary 9, 2012, at 5:00 p.m., in					
1	wheelchair the lan	aled the resident in the ray in place, the shoulder		ĺ.			28
1	IIIIIIODIIIZEI BIOUNG	The facidant's short +- Ju					
1	LASIDALIC S DIISIGISI M	fists attached with a vert					
1	strap to the immobili	zer (different application).					
		uary 14, 2012, at 7:30 a.m.,					
100	on the 200 Hallway I	PVRSIAC the regident in the					
	miceleral, the land	av in histor and the	*			1	
10		De residente cheet and the		1			
10	nancami arrached M	In a Veloro etron to the					
Į,	immobilizer. (differen	t application)					
(Observation on Febr	uary 14, 2012, at 10:50 a.m.,		ľ			
1 .	THE HOLL LODGE LEV	Paled the resident :- 11.		1		İ	
1.4	micologiali, life lan m	av in place the short		1			
10.00	minophilize alouling	le resident's chast and the					
1.7	Sur and leif alling 90	acred with a Volore of (
	ile ililijobilizer (ulile)	ent application).					
(0	bservation with the	Nursing Home Administrator		1			
				1			
44	meelchair, the arms	Un Brand the transfer					
1 2 2	S. T. WILL WILLS AN	acred with a Valar					
	ie immobilizer (differ	ent application).				1	
CMS-2567(02-99) Previous Versions Obs	solote					
	- TO TENSIONS ODS	solcte Event ID: 9D8D12	Fac	llity ID: TN6201	If continue		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Taran san sa		OMBING	0.0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY LETED
		445457	B. WING_	· · · · · · · · · · · · · · · · · · ·		R
NAME OF	PROVIDER OR SUPPLIER		1000		03/	12/2012
EAST TI	ENNESSEE HEALTH (CARE	. 4	REET ADDRESS, CITY, STATE, ZIP CODE 165 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID			-
PREFIX TAG	(EUCH DEVICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULDEE	(X5) COMPLETION DATE
{F 318}	, and the same particular particu	900	{F 318}		and the second s	
	Interview with the N	HA on February 14, 2012, at				
	r r.vo a.m., mule m	ONI IODDY Confirmed the				
	SHOULUEL IMMODILIZE	"Was used to keep the day				
	immobilizer was not	table and the shoulder applied correctly.				
	Interview with Certifi	ed Occupational Therapy				
	Vasionalin (COTALE)	OD Echruse 44 Anda -4				
1	THE PARTY HILL ME SM	all filling room, confirmed				
İ	THE SELVICE USE	applied a chaulder				
	had not been evalua	esident and the immobilizer ted or assessed by Physical				
1	THEIRPY OF OCCUDATI	ODAL Lherany Eurhor				
10	interview confirmed.	The recident has limited				
13	ROM (Range of Moti resident, I'm going to	On) this is a decline for this				
	Interview with Directo	or of Nursing (DON) on			-	
1.2	Columny 10, 2012, a	11'21 nm in the Numer	1			
i t	the immobilizer had b	assessment for the use of				
, ,	minoulizer prevented	The recident from manifest				
1 5	ne ann, the Staff had	not been in continued				
11 5	ion to apply the imm	ODHIZOF and had not				,
	ROM exercises.	ons or documentation for				
11	nterview with the MD	S Coordinator on February				
	', ~~ 'A, at 0.00 a m	in the MDS Offers				
	Vimilied the Physics	Thorney staff!				
	"Y INDO Stall Off THE T	TIDOTIONAL limited: Fu				
4	PPCI GVII GITTITIGISTISTIC	ulder, elbow, wrist, arm) on onber 7, 2011, and they				
•	oucu according in the	2 Marrow Minner				
	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	21917 LUMBAR!_L				·
1 4,	STREET THE TEXTORN	S 20t 20000000000				
be	een completed on Ja	nuary 7, 2012, and				
M CMS-2567//						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/201 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 318} Continued From page 18 Physical Therapy Staff had not provided any {F 318} information for coding the functional limitations of the resident's upper extremities. Continued interview confirmed the facility started using an arm sling on December 2, 2011, and the shoulder immobilizer on February 4, 2012. Interview with the COTA #2 on February 17, 2012, at 8:10 a.m., in the living room, confirmed the resident's left and right arms, and bilateral shoulders had a functional limitation in ROM in the bilateral arms and shoulders. Interview with the DON on February 17, 2012, at 8:15 a.m., in the living room, confirmed the Comprehensive Assessment completed on January 7, 2012, assessed the resident with no functional limitation in ROM and the facility has no documentation or knowledge of a decline in ROM in the resident's medical record until February 14, 2012. Interview by telephone with the Occupational Therapy Registered (OTR) on February 17, 2012, at 1:10 p.m., in the Staffing Coordinator's Office, confirmed ROM should be performed when an immobilizer is used to prevent a decrease in ROM, and schedule for how long the immobilizer is to be left in place. Interview with the resident's Medical Doctor by telephone on February 21, 2012, at 9:12 a.m., confirmed the Medical Doctor visited the resident February 20, 2012, and the resident had a decrease in ROM and ROM exercises should have been performed by the facility to prevent a decline in the resident's condition. 483.25(h) FREE OF ACCIDENT {F 323} {F 323} FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9D8D12 Facility ID: TN6201

-1-

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	·			OMB NO	0.0938-039
NO PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1	IULTIPLE ILDING	CONSTRUCTION	(X3) DATE S COMPL	SURVEY
	445457	B. WII	۱G		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	R
NAME OF PROVIDER OR SUPPLI	ER	 _	CTREET	ADDRESS AITH		2/2012
EAST TENNESSEE HEALT	H CARE		465 IS	ADDRESS, CITY, STATE, ZIP CO BILL RD SONVILLE, TN 37354	DDE	**
LUCLIY COVOUR DELICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EAGH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDE	COMPLETION DATE
(F 323) Continued From SS=E HAZARDS/SUP	page 19 ERVISION/DEVICES	{F 3;	23) F	7 323	2	
environment rem	by must ensure that the resident ent remains as free of accident hazards sible; and each resident receives			83.25 (h) Free of Accide	ent	
adequate superv	ISION and assistance devices to			S=E Requirement:		
Based on medicate review, Guidance Drug Administratifunterview, the facilian sideral restrains with full side rails two residents reviewed for side reviewed for side reviewed for sideral reviewed for sideral residents (#57, #9) residents reviewed supervise to preven forty-three residents. The facility provides Compliance on Macconducted on Manaconducted on Mana	ENT is not met as evidenced al record review, facility policy for Industry and FDA (Food and on) Staff, observation, and lity failed to reduce or eliminate after multiple falls from the bed in use, for one resident (#41) of ewed, failed to identify the risk ment for two residents (#18, nts of twenty-three residents ails, failed to assure safety and properly operating for two 4) two of two residents of ten if for accidents, and failed to nt falls for one resident (#55) of ts reviewed. Ind a Credible Allegation of troh 5, 2012. A revisit ch 12, 2012, revealed the mplemented on March 5, Immediate Jeopardy. TF-221 continues at a "E" level or more than minimal harm).		E SI PI PI PI PI PI PI PI PI PI PI PI PI PI	the facility will ensure the esident environment remanded it hazards as possible esident receives adequate apervision and assistance revent accidents. Orrective Action: (a) Upon review of the Hassessment on 2/6/12 come e licensed nurse the system view of risk factors indicated for the risk factors. The estermined that he was not andidate for the use of side impaired judgment, income side rails were removed 6/12 by the Maintenance for the Ma	ains free of e; and each devices to Pall Risk pleted by ematic sated a risk resident tors from t was a le rails due ontinence, s bed.	

PAGE 80/99 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/20: FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 323} Continued From page 19 SS=E HAZARDS/SUPERVISION/DEVICES side rails and low bed with one mat) {F 323} to the direct caregivers on the Nurse The facility must ensure that the resident Aide Communication Worksheet and environment remains as free of accident hazards the Care plans on 2/6/12. On 2/17/12 as is possible; and each resident receives adequate supervision and assistance devices to a telephone order was obtained by prevent accidents. the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair. This REQUIREMENT is not met as evidenced The resident remains on a low bed with one mat at bedside after Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and receiving a telephone order from the Drug Administration) Staff, observation, and physician on 2/23/12. The resident's interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed care plan was updated on 2/24/12 by with full side rails in use, for one resident (#41) of the Interim MDS Coordinator to two residents reviewed, failed to identify the risk reflect the current orders and for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents interventions (other interventions: reviewed for siderails, failed to assure safety involve in activities, slip resistant devices were on and properly operating for two footwear, may place in the sight of residents (#57, #94) two of two residents of ten staff when awake, rest periods as residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of needed, family at bedside sessions forty-three residents reviewed. throughout the day, get patient up when trying to get out of bed, offer The facility provided a Credible Allegation of snacks, attempt to keep resident dry Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the or clean immediately after corrective actions implemented on March 5, incontinent episode). The care plan 2012, removed the Immediate Jeopardy. was audited by the Nursing Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). Administration Staff to ensure that

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings included:

Event ID:9D8D12

Facility ID: TN6201

the plan of care had been updated to

reflect the resident's current status on 2/24/12. Resident was hospitalized

EAST IN HEALTH CARE PAGE 81/99

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRINTED: 03/14/20 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-035 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 323} Continued From page 19 SS=E HAZARDS/SUPERVISION/DEVICES {F 323} from 2/24/12 to 3/2/12, returning with a change in medical status. The The facility must ensure that the resident Fall Risk Assessment updated on environment remains as free of accident hazards 3/5/12 by the Director of Nursing as is possible; and each resident receives adequate supervision and assistance devices to reflects that resident no longer prevent accidents. attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of This REQUIREMENT is not met as evidenced falls. He is on the FROG Program by: that provides closer observation from Based on medical record review, facility policy various staff members. Resident review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and was transferred to the hospital interview, the facility failed to reduce or eliminate again on 3/9/12 after visit by a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of attending physician. MDS two residents reviewed, failed to identify the risk Coordinator completed a for side rail entrapment for two residents (#18, discharge assessment on 3/9/12. #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety Resident was readmitted on devices were on and properly operating for two 3/15/12 with admitting Charge residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to Nurse completing Fall Risk supervise to prevent falls for one resident (#55) of Assessment and Evaluation for forty-three residents reviewed. the Use of Side Rails with the The facility provided a Credible Allegation of recommendation to be that side Compliance on March 5, 2012. A revisit rails were not indicated at that conducted on March 12, 2012, revealed the corrective actions implemented on March 5, time. Resident's care plan was 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9D8D12

Facility ID: TN8201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/14/2011 ΕE 9.

STATEME	NT OF DEFICIENCIES	& MEDICAID SERVICES			FO	RM APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION		VO. 0938-03
		I WOM NOW, BER:	A BUILE		CON	E SURVEY
		445457	B. WING			R
NAME OF	PROVIDER OR SUPPLIER				0:	3/12/2012
EAST T	ENNESSEE HEALTH O	ARE	. S	TREET ADDRESS, CITY, STATE, ZIP COD 465 ISBILL, RD	ε	
	T — — — — — — — — — — — — — — — — — — —			MADISONVILLE, TN 37354		*
(X4) ID PREFIX	1 VECCH DEFICIENTY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORP	ECTION	
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOLLIDE	(X5) COMPLETION
				DEFICIENCY)	PROPRIATE	DATE
{F 323}	Continued From pag	ie 19				
SS=E	HAZARDS/SUPERV	/ISION/DEVICES	{F 323		a	
3	Stores on			significant change assessi	nent.	
i	environment remains	ure that the resident		Resident's care plan is up	dated	
	do is possible. and e	s as free of accident hazard ach resident receives	1	per MDS and/or Charge N	Jurse on	
	aucquate supervision	and assistance devices to		ongoing bases and as need	ded with	
1	prevent accidents.			any new orders, interventi	ons, or	
				changes.	,	
				(b) Resident #18 The side rai		
	This REOLUDEMENT			were in place during the surv	us that	
- 1	Ψy.	is not met as evidenced		immediately changed to full	ey were	
	Based on medical re	cord review, facility policy		entrapment rails on 2/6/12 by	anu-	
10.5	eview, Guidance for	Industry and EDA /E	d l	Maintenance Director after re	ceirine	
1	and munification.	Staff, observation, and ailed to reduce or eliminate		a physician's order. The	cetamg	
1.	a siderall resulaint affe	or multiple follo from the I	.	measurements for the bed zon	ies were	
100	THE PART SINE LOUIS IN US	A TOT ODO rocident (HAA)		obtained by the Maintenance		
1 -	CONCINCINO LEVIENDE	d, failed to identify the risk of for two residents (#18,		Director on 2/6/12 using a sta	ndard	
1 "	AND LESIGEDIS	of TWODAY, throat coaldent		tape measure with measureme	ents	
1000	SUKTABLIS TO DEMAN	Tailed to pecure		The Staffing Coordinator wron	te a	
1 4	CALCES MELE OU SUU L	roperly operating for two of two residents of ten		narrative note in the nurses no	tes on	
112.2	ACTUS LEVIEWED TOL	accidents and I-11-11		2/6/12 describing the resident	with	1
10000	LA PROPERTY OF THE PROPERTY IS	US TOT ODD regident /4551		limited functional status using	the	
10	orty-three residents re	viewed.		side rails as a restraint. A Phy-	sical	
T	he facility provided a	Credible Allegation of		Restraint Assessment was und:	ated on	
-	PITIPHOLICE OIL WATCH	5 2012 A		2/6/12 for the use of side rails.	A	
100	muducted on March 12	2012 rovening 41		Side Rail Assessment and Infor	rmed	
	orrective actions imple 112, removed the Imp	Courte leasure		Consent was signed by the fam	ily ôn	
1	ALL CALLINING LICE LOLDER	TO TOTAL PROPERTY AND A STREET		2/13/12. On 2/20/12 the MDS		
Cit	auon (potential for mo	ore than minimal harm).		Coordinator completed an Eval	uation -	
	e findings included:	10.5%		for use of Side Rails with a redi	uction	*
			1	in side rails from full (anti-		i

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445457	B. WING		R
NAME OF F	ROVIDER OR SUPPLIER	443457			03/12/2012
	ENNESSEE HEALTH C	ARE	46	EET ADDRESS, CITY, STATE, ZIP CODE 55 ISBILL RD IADISONVILLE, TN 37354	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 323} \$\$=E	HAZARDS/SUPER' The facility must entenvironment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENTENDER.		{F 323}	entrapment) to ½ rails, the phy was notified and order was obfor ½ rails. The measurements bed zones were obtained by the Maintenance Director on 2/20. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's sid was climinated and the resider placed on a low bed with mats Physical Restraint Assessment	tained s for the le /12. le rails at was s. The
	review, Guidance fo Drug Administration interview, the facility a siderail restraint at with full side rails in two residents review for side rail entrapmed (460) of two residents reviewed for siderails devices were on and residents (#57, #94) residents reviewed for supervise to prevent forty-three residents.	r Industry and FDA (Food and Staff, observation, and failed to reduce or eliminate for multiple falls from the beduse, for one resident (#41) of ed, failed to identify the risk ent for two residents (#18, so of twenty-three residents s, failed to assure safety properly operating for two two of two residents of ten or accidents, and failed to falls for one resident (#55) of reviewed.		completed on 2/28/12 by the S Coordinator for the elimination side rails and the use of a low with mats after receiving a physician's order. The care physician's order. The care physician's order. The care physician's order. The care physician's order. The care physician's order. The care physician's order. The care physician's order. The care physician's order to ensure the plan of care had been updated to upper lip with intervention of bed with a small lace to upper lip with intervention.	staffing on of bed slan sthat ated to tatus on rolled ration on to
	compliance on March conducted on March corrective actions im 2012, removed the Ir Non-compliance for I	h 5, 2012. A revisit 12, 2012, revealed the plemented on March 5, mediate Jeopardy. =221 continues at a "E" level more than minimal harm).		check placement of furniture remove if in pathway. Keep free of clutter for safety. Bo and bladder program to dete habit time, and FROG Program Care plan was updated to re- new interventions for 3/5. 3	e and proons wei rmine ram. fleet

04/02/2012 08:11 4234424465

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FRINTED: 03/14/20 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVE IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-039 (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE (F 323) DEFICIENCY) Continued From page 19 SS=E | HAZARDS/SUPERVISION/DEVICES resident was found in room 129 {F 323} bathroom with one shoe on. The facility must ensure that the resident Resident had gotten up from her environment remains as free of accident hazards as is possible; and each resident receives wheel chair in another resident's adequate supervision and assistance devices to room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to This REQUIREMENT is not met as evidenced screen. On 3/15, further intervention was added to get up Based on medical record review, facility policy after breakfast as desires after review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and further investigation of fall on interview, the facility failed to reduce or eliminate 3/13. Fall on 3/17 where resident a siderail restraint after multiple falls from the bed rolled from the bed in her sleep, with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk bed was in lowest position with for side rail entrapment for two residents (#18, mats on both sides, no injury #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety noted, intervention to add pool devices were on and properly operating for two noodles to define perimeter of the residents (#57, #94) two of two residents of ten bed with all above interventions residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of added to the care plan as forty-three residents reviewed. implemented. Resident's care The facility provided a Credible Allegation of plan is updated per MDS and/or Compliance on March 5, 2012. A revisit Charge Nurse on an ongoing conducted on March 12, 2012, revealed the bases and as needed with any new corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. orders, interventions, or changes. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: FORM CMS-2567(02-99) Previous Versions Obsoleto Event ID:9D8D12 Facility ID: TN6201 If continuation sheet Page 20 of 38

FORM CMS-2587(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FRINTED: 03/14/2012 FORM APPROVED

CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-03	
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE (COMPL	SURVEY
		445457	B. WING_			R
NAME OF	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	03/	12/2012
	TENNESSEE HEALTH	1000000 (6000) Chi S	4	65 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	THUM DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	UID BE	(X5) COMPLETION DATE
	The facility must er environment remains is possible; and adequate supervisity prevent accidents. This REQUIREMENT by: Based on medical review, Guidance for Drug Administration interview, the facility a siderail restraint ar with full side rails in two residents reviewed for side rail entrapment (#50) of two residents reviewed for siderails devices were on and residents (#57, #94) residents reviewed for supervise to prevent forty-three residents The facility provided Compliance on March corrective actions impact (#50), removed the Interviewed for supervise to prevent forty-three residents.	asure that the resident ins as free of accident hazards each resident receives on and assistance devices to instance from the tent of the reduce or eliminate from the beduse, for one resident (#41) of red, failed to identify the risk ent for two residents (#18, is of twenty-three residents instance from the two of two residents of tent or accidents, and failed to falls for one resident (#55) of reviewed. The Credible Allegation of the property operating for two two of two residents of tentor accidents, and failed to falls for one resident (#55) of reviewed. The Credible Allegation of the property operating the property operation of the fallegation of the falle	{F 323}	(c) Resident # 60 The side rathat were in place during the surver immediately changed to fur anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 the Maintenance Director. The measurements for the bed zones obtained by the Maintenance Director on 2/6/12 using a standard tape measure. The Side Rail Assessment and Informed Constrom (one form) was later comply the Staffing Coordinator on 2/6/12 for the use of side rails reduction from full side rails to side rails after receiving a physician's order for the use or rails by the Staffing Coordinat (after the exit of the surveyors evening) that were changed out the Maintenance Director. The zone measurements were obly the Maintenance Director 2/6/12. A Pre-Restraint Assessment was completed 2/21/12 by the Staffing	rvey all ne by s were dard cent pleted with a o ½ f ½ cor for the at per e bed otained or on	
-	The findings included	:				

Event ID:908012

Facility ID: TN6201

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	H AND HUMAN SERVICES E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(×2) MU	ILTIPLE CONSTRUCTION	OMB M	M APPE O. 0938
			A. Bull,	DING	(X3) DATE	SURVEY LETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING		1	R
EAST T	ENNESSEE HEALTH		-1-10	TOFF	03/	12/201
		CARE	١	TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ID	PROVIDER'S DI ANI SE		
		- ING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE	JLD BE	COMPL
{F 323}	Continue			CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE	DAT
		je 19	f=	Carati		
	HAZARDS/SUPERV	ISION/DEVICES	{F 323}		de	
1	The facility must an-	MANAGEMENT AND AND THE PROPERTY OF THE PROPERT		lans being used as a rectraint		
	environment remains	ure that the resident as free of accident hazards		assisting the resident Recide		151
	as is possible; and ea	as tree of accident hazards ach resident receives		was transferred to hospital and	110	
1	prevent accidents.	ach resident receives and assistance devices to		2/20/12. The Interim MDG		
1	oolderits,	,,,		Coordinator completed a		
				Discharge Assessment on 2/29		
				which reflected the use of side	⁷ /12	
T	his REQUIREMENT	is not met as evidenced	1	rails as a restraint		
b	y:	is not met as evidenced		rails as a restraint (as ½ rails w	ere	
re	sased on medical rec	ord review, facility policy		used until 2/23/12 during the 7		
Di	rug Administration) o	Gasty and FUA (Food and		day look back period). The		
l int	lerview the facility r	boservation, and		resident was reassessed upon	1	
as	siderail restraint after	multiple falls from the bed	Ĺ	return to the facility on 3/12/12	by	
TWO	O residente rouleur	of lesident (#41) of		the admitting Charge Nurse who	^	
TOL	Side rail entren-	, and to identify the risk	1	completed an Evaluation for the	. 1	
J #6(D) of him regident	Wo residents (#18		use of Side Rails and a Fall Risk		
/ dev	ICES WORD OF	wed to assure safety		Assessment with the		
/ resi	dents 1#57 #04	perly operating for two	1	recommendation for no side rails	_	
resi	dents revious d	or the residents of ten	j	indicated at this time. The MDS	8	
forty	three residents	ccidents, and failed to for one resident (#55) of		Coordinator completed a 5 day		
11			1	Readmission Assessment on		
The	facility provided a Crapliance on March 5	edible Allegation	3	1/22/12 (A 14.4		
Cond	pliance on March 5,	2012. A revisit	1 12	/22/12. (A 14 day Assessment		
COLLE	ective actions in a	2012, revealed the	T T	vas completed on 3/29/12).	1	
	. removed the	on March 5		esident's care plan is updated	1	
2012		veopardy	Į pe	er MDS and/or Charge Nurse on		
Non-	compliance for F-221	continues at a "="	V	Oli		
Non-citatio	on (potential for more	continues at a "E" level	ai	ongoing base and as needed		
Non-citatio	compliance for F-221 on (potential for more indings included:	than minimal harm).	all	ongoing base and as needed ith any new orders, terventions, or changes.		

4234424465 04/02/2012 08:11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FRINTED: 03/14/20 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA FORM APPROV IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-03 (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 465 ISBILL RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID MADISONVILLE, TN 37354 PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION {F 323} Continued From page 19 DEFICIENCY) DATE SS=E | HAZARDS/SUPERVISION/DEVICES (d) Resident # 57 A telephone order {F 323} was received from the resident's The facility must ensure that the resident physician for the use of 1/2 side rails environment remains as free of accident hazards as is possible; and each resident receives on 2/10/12. The resident was adequate supervision and assistance devices to assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of side rail use) indicating the use of 1/2 side rails by the Staffing Coordinator. A Pre-This REQUIREMENT is not met as evidenced Restraint Assessment was completed Based on medical record review, facility policy on 2/21/12 by the Director of review, Guidance for Industry and FDA (Food and Nursing that indicated side rails are Drug Administration) Staff, observation, and used as a restraint. On 2/24/12 interview, the facility failed to reduce or eliminate another Evaluation for the use of a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of Side Rail was completed by the two residents reviewed, failed to identify the risk Staffing Coordinator indicating the for side rail entrapment for two residents (#18, elimination of 1/2 side rails (no side #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety rails are in place at this time). As of devices were on and properly operating for two 2/24/12 the resident's current residents (#57, #94) two of two residents of ten interventions include: the locking of residents reviewed for accidents, and failed to wheel chair prior to transfer, offer supervise to prevent falls for one resident (#55) of forty-three residents reviewed. rest periods, assist to the bathroom during rounds and as needed, bed in The facility provided a Credible Allegation of lowest position, a chair sensor pad. Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the The care plan was audited by the corrective actions implemented on March 5, Nursing Administration Staff to 2012, removed the Immediate Jeopardy. ensure that the plan of care had been Non-compliance for F-221 continues at a "E" level updated to reflect the resident's citation (potential for more than minimal harm). current status on 2/29/12. The care The findings included: plan was audited by the Nursing Administration Staff to ensure that FORM CMS-2567(02-99) Previous Versions Obsolete the plan of care had been updated to Event ID:9D8D12 Facility ID: TN6201 If continuation sheet Page 20 of 38

04/02/2012 08:11 4234424465

AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	TH AND HUMAN SERVICES RE & MEDICAID SERVICES		F	RINTED: 03,
	TOMICOTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	The state of the s	FURM ADD
		1	A BUIL	DING (X	MB NO. 093
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING		COMPLETED
FAST	ENNER		D. VVIIVE		R
-7.011	ENNESSEE HEALTH	CARE	s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/12/201
(X4) 1D	SUMMAN				
PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMAT.		MADISONVILLE, TN 37354	
	TEGOLATORY OR L	Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREFIX	PROMDERIO	
Maria restaurante de la companya del companya de la companya del companya de la c			TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE ABOULD E	SE COMP
{F 323}	Continued From pa			CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DA
SS≒E	HAZARDS/SUBER	ge 19			
	HAZARDS/SUPER	VISION/DEVICES	{F 323}	reflect the resident's current status	s on
1	The facility must			The Tegidant's	
	as is possible	sure that the resident s as free of accident hazards ach resident receiver		"as teviewed by the Diractan a	- 1
].	adequate support	s as free of accident hazards ach resident receives		or 3///12 and evaluated	or
11	prevent accidente	ach resident receives n and assistance devices to		Proveilion strategies	ed
	old Girls.			mici velition for constant	
1		1		supervision during toileting	
				mappropriate. After review -c	
T	his REQUIPEMENT			current interventions on 3/7/10 t	ĺ
b	A:AOUVEINIEUL	is not met as evidenced		and Office of Of Nitreing and c	
, .	doed on mod:			The incident ()	
I D	view, Guidance for I	cord review, facility policy ndustry and FDA (Food and		THE VEILLON BOT TO LEAVE MANY	
				" " " uctormined that the	9 9
1 54 5	Siuerall rootest.	TO TEULIER OF Alies!		Intervention was implemented to	
77.14	III IUII SIGA PARA	The least trops that I		" Turi Tool Called analysis	*
				conducted (the intervention	
			ļ	2010 Veu as of 2/24/12 into-	
			- 1	AS OF 3/22/12 AS OF	
			1	microentions, the resident com-	
			1	TOU DEOGRAM norti-	İ
			1 0	with ambulation 4	
forty	three residents revi	ccidents, and failed to s for one resident (#55) of ewed.	0	dine program", low bed with mats,	
 	. andents team	ewed, (#05) or	a	intiroll back brakes, the locking of	
Com	facility provided a Cr pliance on March 5.	ediblo All	\ u	wheel chair prior to transfer, offer	
COUG	pliance on March 5, ucted on March 12	2012 A revisit	re	est periods, assist to the bathroom	
COLLE	CIIVA DOLL-	-VIA. Tevesion the	di	uring rounds and as	
I SUIZ	IPMANA III	TINGU ON MARKE P	m	uring rounds and as needed, further	
1 11011-0	JUMPHUMP	ADS ARODSING	1	and interventions	1
citatio	n (potential for more	continues at a "E" level than minimal harm).		define to prevent falls Doniday	
		man minimal harm).	Ca	re plan is current and updated	
1,110 111	ruings included:			, —mv4	T
	Previous Versions Obsolete	1 -			
-2567(02-99)	Previous Van-				

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRINTED: 03/14/2010 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) (F 323) Continued From page 19 per MDS and/or Charge Nurse on HAZARDS/SUPERVISION/DEVICES SS=E {F 323} an ongoing bases and as needed The facility must ensure that the resident with any new orders, environment remains as free of accident hazards interventions, or changes. as is possible; and each resident receives adequate supervision and assistance devices to (e) Resident #94 The facility staff prevent accidents. provides supervision through routine rounds (minimum of every 2 hours), during care delivery, activities, and meals. The chair sensor pad was This REQUIREMENT is not met as evidenced discontinued on 3/5/12 by the by: Based on medical record review, facility policy Director of Nursing after reviewing review, Guidance for Industry and FDA (Food and current interventions. After placing Drug Administration) Staff, observation, and the resident in the correct wheel chair interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with anti-lock brakes on 2/6/12 the with full side rails in use, for one resident (#41) of resident was identified not to be at two residents reviewed, failed to identify the risk risk for falls of a similar incident for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents (wheel chair rolling back). The reviewed for siderails, failed to assure safety resident utilizes the wheel chair to devices were on and properly operating for two push himself into a standing position; residents (#57, #94) two of two residents of ten the anti-lock brakes prevent the chair residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of from rolling providing the resident forty-three residents reviewed. with stability. An identifier with the resident's name was attached to the The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit wheel chair on 2/29/12. The conducted on March 12, 2012, revealed the resident's care plan was reviewed corrective actions implemented on March 5, and updated by the Director of 2012, removed the Immediate Jeopardy. Nursing on 2/29/12 to reflect the Non-compliance for F-221 continues at a "E" level resident's current status. After citation (potential for more than minimal harm). review of current interventions on The findings included:

Event ID: 9D8D12

3/7/12 by the Director of Nursing

Facility ID: TN6201

04/02/2012 08:11

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRINTED: 03/14/2019 FORM APPROVES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 R NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 323} Continued From page 19 (f) Resident #55 care plan was {F 323} HAZARDS/SUPERVISION/DEVICES reviewed and modified on 2/14/12 by the MDS Coordinator and The facility must ensure that the resident environment remains as free of accident hazards reflected the resident's current as is possible; and each resident receives status. No further assessments or adequate supervision and assistance devices to care plan updates could be prevent accidents. completed due to the resident expiring on 2/16/12. 2. (a) The Fall Risk Assessment for This REQUIREMENT is not met as evidenced all residents (utilizing the current Based on medical record review, facility policy assessment) was reviewed and review, Guidance for Industry and FDA (Food and verified to be correct by the Nursing Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate Administration Team on 2/28/12. a siderail restraint after multiple falls from the bed The nursing administration team with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk reviewed and revised the care plans for side rail entrapment for two residents (#18, for residents that scored at high risk #60) of two residents of twenty-three residents for falls ensuring that fall reviewed for siderails, failed to assure safety devices were on and properly operating for two preventative interventions have been residents (#57, #94) two of two residents of ten implemented on those as of 2/28/12 residents reviewed for accidents, and failed to through 3/5/12. As of 3/5/2012, 11 supervise to prevent falls for one resident (#55) of forty-three residents reviewed. residents scored High (20 or above) on the Fall Risk Assessment. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit (b) The charge nurse or a member of conducted on March 12, 2012, revealed the nursing administration will complete corrective actions implemented on March 5, a Fall Risk Assessment upon 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level Admission/Readmission, significant citation (potential for more than minimal harm). change, after a fall, and at minimum The findings included: of quarterly. The charge nurse will implement a new or modified FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12

Facility ID: TN6201

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRINTED: 03/14/2012 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING R NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 323} Continued From page 19 intervention (updating the Nurse HAZARDS/SUPERVISION/DEVICES {F 323} Aide Communication Sheet, 24 hour The facility must ensure that the resident report sheet, and care plan) to environment remains as free of accident hazards prevent further falls. The Director of as is possible; and each resident receives Nursing or Assistant Director of adequate supervision and assistance devices to prevent accidents. Nursing will in-service staff on any modifications made regarding fall interventions after the morning QA Meeting (where occurrences/falls are This REQUIREMENT is not met as evidenced discussed). A Fall Focus Committee by: Based on medical record review, facility policy consisting of the Interdisciplinary review, Guidance for Industry and FDA (Food and Team (not limited to: Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate Director/Assistant Director of a siderail restraint after multiple falls from the bed Nursing, MDS Coordinator, Social with full side rails in use, for one resident (#41) of Services, Activity Director) is two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, conducted monthly, and or as needed #60) of two residents of twenty-three residents to recap occurrences that have reviewed for siderails, failed to assure safety devices were on and properly operating for two occurred during the month and residents (#57, #94) two of two residents of ten evaluate the success of implemented residents reviewed for accidents, and failed to interventions (occurrences are supervise to prevent falls for one resident (#55) of forty-three residents reviewed. discussed/reviewed daily (Monday-Friday) in the QA meeting). A The facility provided a Credible Allegation of review of all residents MDS's and Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the Care Plans was initiated on 2/28/12 corrective actions implemented on March 5, to identify other assessments or Care 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level Plans that may not have been coded citation (potential for more than minimal harm). or updated correctly for the use of side rails/restraints. Resident's that The findings included:

Event ID:9D8D12

If continuation sheet Page 20 of 38

are identified as being out of

Facility ID: TN6201

AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	H AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FRINTE FOR	NVI APP
i oceana m en	, O. COKKECTION	IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	OWR M	<u>O.</u> 093
			A BUILD	DING	(X3) DATE	SURVEY
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING			
F40=-	- HOVIDER OR SUPPLIER				000	R
CASI I	ENNESSEE HEALTH O	ARE	S	TREET ADDRESS, CITY, STATE, ZIP CODE		12/201
(X4) ID				THE POLICE IND	•	i.
PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING MEAN		MADISONVILLE, TN 37354		
	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRE	CTION	T
82.5%			TAG	CROSS-REFERENCED TO THE AD	HOULD BE	COMP
{F 323}	Continued From pag		 	OLI (OIGNUY)	MOTHINE	DA
SS=E	HAZARDS/SUDED	e 19	{F 323}	compliance will have a		 -
	HAZARDS/SUPERV	ISION/DEVICES	11-323}	modification/significant cha		
	The facility must ensi-	ura that w		and/or revision to discontinua	nge	
j	environment remains	as free of accident hazards		and/or revision to the Care F	lan to be	
9	as is possible; and ea	ach resident receives		Product to reflect the!	dent's	
1	prevent accidents.	each resident receives n and assistance devices to		Status by the Mario		
1	in the accidents.			Coordinator(s) The North	т	
1		1		runingstrative staff conducts	1	
		1		walking rounds to compare the	od p	
1.	This Draws		1	resident's current :	ie	
1	by:	is not met as evidenced	1,	resident's current intervention	is (list	
1	Based on madical		1.0	and inclusive, to includ-	c 1	
	eview, Guidance for Ir	ord review, facility policy		- 1. Toos such as alarma -t.		
) L	Jrua Administration	Mustry and FDA (Food and	,	The bounty, UCOS mate old-	*7	
l a	siderall read facility fai	taff, observation, and iled to reduce or eliminate	, ,	"Lancis) against the care willing		
1 W	ith full side rolle in	The rails from the bed	1	moute that no other resident		
) (V	VO residente roui-	The resident (#41) of	10	callected by this deficient		
1 10	F Side rail ontran.	ioned to identify the risk	0	n 2/28/12. The individual resi	actice	
#6	00) of two residents of	for two residents (#18, twenty-three residents	n	ced for supervision	dent's	
de	viewed for siderails, fa	alled to assure safety	n	eed for supervision and curren	it fall	
re:	Sidents (#57 #00)	being operating for two	1	of the litterventions woo	1	
163	SIDENTS reviewed to	- The residents of ten	1 4	dated as needed on to the At-	rse	
SU	pervise to prove-4 "	and tailed to	1 4 21	de Communication Chart	1	
TOP	ty-three residents revi	ewed.	3.	(a) The nursing administration	n l	
			Sta	iff communicated changes to	1	
Co	e facility provided a Cr mpliance on March 5, iducted on March 12	edible Allegation of	res	ident status such as bed chang	TOC	
COL	ducted on March	2012. A revisit	mo	dification of side rails, or	500,	
cor	rective actions implem 2, removed the Imme	lented on Marria	mo	diffication to mantains, or		
Non	2, removed the Imme	diate Jeonardy	din	dification to restraint usage t	o the	
cital	tion (notantial f	diate Jeopardy. continues at a "E" level	—— —	ect care givers (CNA's, licen	sed	
1	10 10 10 10 10 10 10 10 10 10 10 10 10 1	than minimal harm)	nur	ses, and therapist) on the Nur	50	
The	findings included:		Aid	le Communication Worksheet	. 1	
			Car	e Plans, and/or the 24 hour re	nort	
>-2567(02-9	9) Previous Verslons Obsolete		boo	k as of 2/28/12. The Assistar	POIL	
		Event ID: 9D8D12				

AND PLAT	ARTMENT OF HEAL ERS FOR MEDICAP ENT OF DEFICIENCIES NOF CORRECTION					FRINT	ED: 03
	- MAZE MON	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2);	MIL	Tipi =		
		f	A. BU	III r	TIPLE CONSTRUCTION	OMB N	<u>10.09</u> ;
NAME OF	PROVIDER OR SUPPLIER	445457	B. Wil		6) <u>294 - 3</u> 00 - 500	COM	E SURVE PLETED
EAST	ENNESS.		15. 7411	140			R
	ENNESSEE HEALTH	CARE	1	SI	REET ADDRESS, CITY, STATE, ZIP CODE	03	/12/20
(X4) ID PREFIX	Strate		- 1		465 ISBILL RD		
TAG	REGULATOR	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INCOME.	- 	_	MADISONVILLE, TN 37354		
	- SENTORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		PROMPERIO		
/E 2001			TAG	•	(EACH CORRECTIVE ACTION SHOOKS). REFERENCED TO THE ACTION SHOOKS	CTION OULD BE	COMP
(F 323)		Te 10	+		CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMP
SS=E	HAZARDS/SUPERV	ASIONIAN	/E 200	0.			1_
j	The facility	IOIOIVIDEVICES	{F 323	3}	Director of Nursing will pos	st an	
1	The facility must ens	ure that the resident		1	updated list for residents wit	h side	
11.00	GO IS DOCALLI			- 1	Tont of the CNIA		
6	adequate supervision	as free of accident hazards ach resident receives			assignment book as changes	_	1
	brevent accidents.	ach resident receives and assistance devices to		1	made to the resident's curren	4 -1 1	
1		*	85	1	tau status beginning 2/20/12	4.17	
1				1	Colucius using wheel chaire	[
1	his nex			1	WILL HAVE TERIMENT COM		
by	NIS REQUIREMENT	is not met as evidenced		i	dentifiers added to their chair	IIIC	
B	ased on medical	as evidenced	1	3	/1/12 by the Maintenance As	by	
re	view, Guidance for la	ord review, facility policy		a	National As	sistant.	
			- 1	(t) Upon admission/readmissi	on.	
las	iderail lacility fai	led to reduce a	1		Sidenis Will be assessed wait	_ 1	
wit	h full side rails is	ed to reduce or eliminate multiple falls from the bed for one resident (#41) of failed to identify the	- 1	щ	Evaluation for the use of st	ide	
two	residents reviewed	for one resident (#41) of failed to identify the risk for two residents (#41)	1 .	,CC	Assessment tool by the	ac	
#60	side rail entrapment	failed to identify the risk for two residents (#41) of larger two residents (#18, larger two two three residents (#18, larger two two two two two two two two two two	1 '	$\mathbf{v}_{\mathbf{L}}$	large Nurse or Muraina	1	
revi	ewed for	twenty-three next (#18,	14	Ad	lministration for the		
devi	ewed for siderails, faices were on and pro	iled to assure safety perly operating for two of two residents	∤a	igr	propriateness of side rails		
resid	dents (#57, #94) two	perly operating for two	10	us	ing the least	1	
Supe	ients reviewed for ac	perly operating for two of two residents of ten cidents, and failed to for one resident	F	ינוי	ing the least restrictive device	e).	
forty-	three residents revie	cidents, and failed to for one resident (#55) of wed.	b	G P	ther side rail evaluations will	1	
-	evie	wed. (#05) of	cl	be.	reviewed with significant		
Com	acility provided a Cre pliance on March 5, 2	dible Au-	01	1 ta	uges, at a minimum as		
condi	oliance on March 5, 2 ucted on March 12, 2	012. A revision of	/ પ્	ua,	rierly and/or as needed in	e	
correc	clive 20th March 12, 2	012. revealed the	1		So nuise. MDS Coording	-	
2012,	removed the Immed ompliance for F-221	nted on March 5	7-4		of Hursing administration		
NON-C	ompliance for F-221-	ate_Jeopardy. continues at a "E" level	1 411		icast restrictive side '1		
oration	(potential for more	han minima at a "E" level	be	us	ed as a restraint only after al		
The fin	dings included:	mal harm).	oth	ıer	alternatives (list not all	1 +	** -
	amgs included:		inci	hre	Sive: love by		
2567(02-99) F	Previous Versions Obsolete		in le	O	sive: low bed with mats, bed est position, pool noodles,	1	
	0020l6(é	Event ID:9D8D12		JN	Lear lood norther di	1	- 1

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MI	ULTIPLE CONSTRUCTION	OMB N	D: 03/14 M APPRO O. 0938-
		Counce time across see 4400.	A BUIL	DING	(X3) DATE	SURVEY LETED
NAME OF	PPC) (IDEA	445457	B, WIN		1	
_	PROVIDER OR SUPPLIER					R
EAST T	ENNESSEE HEALTH C	ADE		STREET ADDRESS, CITY, STATE, ZIP CODE		12/2012
				AA IODICE KD		60
(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES		MADISONVILLE, TN 37354		
TAG	REGULATORY OR LS	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S DI ALLES	OTIA	
(F 323)			TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	CHON DULD BE ROPRIATE	COMPLE DATE
60-5	Continued From pag	e 19		Wing mottes		
00≒E	HAZARDS/SUPERV	ISION/DEVICES	{F 323	wing mattresses, toileting		
!	The factor	- OTHER VICES		schedules, activities, non-s	kid	
!	The facility must ensu	are that the resident		surfaces, modification of re	οom	
ĺ	as is possible.	are that the resident as free of accident hazards		location, observe behavior/	troles	
j	as is possible; and ea	ich resident receives		patterns, assistive devices,	wake	
	prevent accidents.	and assistance devices to		reclining /rocker chairs, dro		
1		1		sente tilt bed to the sente tilt bed	p	
1				seats, tilt back chairs, medic	cation	
ĺ		1		review/adjustment, identific	ation	
This REQUIREMENT i	in		markers (FROG program- p	Tocess		
t	by:	is not met as evidenced		identified later in the F 323	10000	
	Based on medical rec	ord review, facility policy		document), family visits) ha		
	eview, Guidance for Ir	ord review, facility policy ndustry and FDA (Food and	i	been attempted and	ve	
ic	Orug Administration) S hterview, the facility fai	taff, observation and		been attempted without succ	ess.	
a	Siderail restraint atta	ned to reduce or eliminate		A Pre-restraint Assessment	will	
l W	ith full side raile in .	moraple rails from the hed I		he completed by the charge	nurse	
1 tv	VO residents rovious	the resident (#41) of		or by a member of the Nursi	no	
10	or side rail entrapment	failed to identify the risk for two residents (#18,		Administration Staff prior to	the	
re	ov) of two residents of	for two residents (#18, twenty-three residents		use of a restraint. The Pre-	tile	
1 06	VICES WATER OF	The to assure safety		Restraint Agents		
re:	Sidents (#57 #04)	peny operating for two		Restraint Assessment will gu	ide	
l res	Sidents reviewed ?	of the residents of ten		the nurse in making a decisio	n if a	
for	pervise to prevent falls	ccidents, and failed to s for one resident (#55) of ewed		restraint is recommended and		
101	ty-three residents revi	ewed, (#55) of	1	offer alternative ideas (on the		
The	e facility provided	4	ļ	back of form) that can reduce	the	
Co	e facility provided a Cr mpliance on March 5, iducted on March 12	earble Allegation of		risk of injuries associate with	dic	
cor	Iducted on March 40	ZUIZ. A revisit		falls/restraints for residents at		
201	rective actions implementally, removed the Imme	Dented on Mose's		high will 6 cor		
- Nor	12, removed the Imme	diate Jeopardy		high risk for falls without the	use	
cita	tion (notential)	diate Jeopardy 1 continues at a "E" lever ——	22 32 44	of a physical device. An	1	
1	S SATA	e than minimal harm)		alternative intervention can be		3.5
The	findings included:			attempted based on the individ		
				tesident's Pre-Restraint	iuai	
-2567(02-9	99) Previous Versions Obsoleto]	Assessment in no specific orde		
		Event ID:9D8D12		. MOUSOUICHE III no enecifie and	see I	

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FRINTED: 03/14/201 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION FORM APPROVE OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE DEFICIENCY {F 323} Continued From page 19 HAZARDS/SUPERVISION/DEVICES \$S=E be updated on an ongoing basis {F 323} for interventions that have been The facility must ensure that the resident environment remains as free of accident hazards attempted without success with as is possible; and each resident receives the date written to the side of the adequate supervision and assistance devices to intervention attempted. If a prevent accidents. restraint is recommended, the resident will be assessed at a minimum of quarterly and/or as This REQUIREMENT is not met as evidenced needed to determine if the by: restraint is still appropriate or if a Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and reduction can be attempted. Drug Administration) Staff, observation, and After the completion of an interview, the facility failed to reduce or eliminate Evaluation for the use of Side a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of Rail assessment and/or a Pretwo residents reviewed, failed to identify the risk Restraint Assessment, the for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents Maintenance Director or reviewed for siderails, failed to assure safety Maintenance Assistant will be devices were on and properly operating for two notified by the nurse of the least residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to restrictive side rails needed to supervise to prevent falls for one resident (#55) of achieve the resident's highest forty-three residents reviewed. physical functioning status. The The facility provided a Credible Allegation of Maintenance Director or Assistant Compliance on March 5, 2012. A revisit will place the appropriate side conducted on March 12, 2012, revealed the corrective actions implemented on March 5; rails on the resident's bed 2012, removed the Immediate Jeopardy. measuring each Zone using a Non-compliance for F-221 continues at a "E" lever standard tape measure, citation (potential for more than minimal harm). documenting his findings on the The findings included: Side Rail Log. The Maintenance

Event ID: 9D8D12

If continuation sheet Page 20 of 38

Director demonstrated the bed

Facility ID: TNG201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2012 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 NAME OF PROVIDER OR SUPPLIER B, WING EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 323} Continued From page 19 zone measuring process to each HAZARDS/SUPERVISION/DEVICES SS=E {F 323} Charge Nurse and a return The facility must ensure that the resident demonstration was performed by environment remains as free of accident hazards each charge nurse (2/7/12 as is possible; and each resident receives adequate supervision and assistance devices to 3/1/12), allowing the nurse the prevent accidents. ability to measure side rails in the absence of the Maintenance Director or Assistant. If a resident's condition changes that This REQUIREMENT is not met as evidenced may require a change in the side Based on medical record review, facility policy rail type, the nurse must first review, Guidance for Industry and FDA (Food and complete a new Evaluation for the Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate use of Side Rail Assessment, a siderail restraint after multiple falls from the bed notify the physician to obtain new with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk orders, then notify the for side rail entrapment for two residents (#18, Maintenance Director and/or #60) of two residents of twenty-three residents Assistant for placement. Side reviewed for siderails, failed to assure safety devices were on and properly operating for two rails will be measured each time residents (#57, #94) two of two residents of ten there is a change in the side rail residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of type, quarterly, and as needed by forty-three residents reviewed. the Maintenance Director or The facility provided a Credible Allegation of Assistant. Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the (c) In-services were conducted on corrective actions implemented on March 5, 2/6/12, 2/7/12, 2/8/12, 2/9/12, 2012, removed the Immediate Jeopardy. 2/13/12, 2/17/12, and 2/24/12 for Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). facility staff by the Administrator, Maintenance Director and/or the The findings included: Director of Nursing regarding but FORM CMS-2567(02-99) Previous Versions Obsolete not limited to: the completion of Side Event ID: 9D8D12

Facility ID: TN6201

04/02/2012 08:11 EAST IN HEALTH CARE 4234424465 PAGE 97/99 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES PRINTED: 03/14/20 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION FORM APPROVE OMB NO. 0938-03 IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 323} Continued From page 19 SS=E HAZARDS/SUPERVISION/DEVICES Rail Assessment and Informed {F 323} Consent, Evaluation for the use of The facility must ensure that the resident Side Rails to be completed prior to environment remains as free of accident hazards the use of side rails. Pre-Restraint as is possible; and each resident receives adequate supervision and assistance devices to Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how This REQUIREMENT is not met as evidenced to obtain bed zone measurements per the FDA "best practice" standards. Based on medical record review, facility policy All staff was again in serviced review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and regarding the above by the interview, the facility failed to reduce or eliminate Administrator, Maintenance Director a siderail restraint after multiple falls from the bed and/or the Director of Nursing on with full side rails in use, for one resident (#41) of 2/29/12. All staff including new two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, hires, contracted staff (performing #60) of two residents of twenty-three residents direct care) and staff on leave of reviewed for siderails, failed to assure safety absence will be in serviced by the devices were on and properly operating for two residents (#57, #94) two of two residents of ten Administrator, Maintenance Director residents reviewed for accidents, and failed to and/or the Director of Nursing supervise to prevent falls for one resident (#55) of regarding but not limited to: the forty-three residents reviewed. completion of Side Rail Assessment The facility provided a Credible Allegation of and Informed Consent, Evaluation Compliance on March 5, 2012. A revisit for the use of Side Rails to be conducted on March 12, 2012, revealed the completed prior to the use of side corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. rails, Pre-Restraint Assessment, Non-compliance for F-221 continues at a "E" level

The findings included:

citation (potential for more than minimal harm).

Physical Restraint Assessment

(when, on whom, why, and how the assessment is to be completed), the

risk of entrapment associated with

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FRINTED: 03/14/2 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FORM APPROV (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-03 A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING EAST TENNESSEE HEALTH CARE R STREET ADDRESS, CITY, STATE, ZIP CODE 03/12/2012 (X4) ID PREFIX 465 ISBILL RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL MADISONVILLE, TN 37354 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION {F 323} Continued From page 19 DEFICIENCY) DATE SS=E HAZARDS/SUPERVISION/DEVICES zone measurements per the FDA {F 323} "best practice" standards prior to The facility must ensure that the resident environment remains as free of accident hazards working their scheduled shift. as is possible; and each resident receives Another in-service was presented by adequate supervision and assistance devices to the Administrator on 3/15/12 to prevent accidents. review survey findings and the plan of correction. (d) The Director or Assistant This REQUIREMENT is not met as evidenced Director of Nursing will provide Based on medical record review, facility policy ongoing education on the review, Guidance for Industry and FDA (Food and importance and implementation Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate of interventions to prevent falls. a siderail restraint after multiple falls from the bed The facility began working with with full side rails in use, for one resident (#41) of Q-Source (October, 2011) on a two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, restraint reduction collaborative, #60) of two residents of twenty-three residents that also provides ideas to assist reviewed for siderails, failed to assure safety with reducing falls. The devices were on and properly operating for two residents (#57, #94) two of two residents of ten Administrator contacted the Qresidents reviewed for accidents, and failed to Source representative who supervise to prevent falls for one resident (#55) of forty-three residents reviewed. registered the Director of Nursing, Assistant Director of The facility provided a Credible Allegation of Nursing, Activity Director and Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the MDS Coordinator for a Physical corrective actions implemented on March 5, Restraint & Pressure Ulcer 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level Regional Collaborative Learning citation (potential for more than minimal harm). Session on April10, 2012. On 3/5/12 the Director of Nursing The findings included: revised the FROG (Fall Reduction ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9D8D12 Facility ID: TN6201 If continuation sheet Page 20 of 38

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2010 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED B. WING 445457 R NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 323} Continued From page 19 Our Goal) Program to increase HAZARDS/SUPERVISION/DEVICES SS=E (F 323) the level of supervision of The facility must ensure that the resident residents identified as being at environment remains as free of accident hazards risk by involving all facility staff. as is possible; and each resident receives adequate supervision and assistance devices to The Director of Nursing prevent accidents. conducted an in-service on 3/5/12 to alert the facility staff on the revised FROG program. Inservices were completed by This REQUIREMENT is not met as evidenced 3/22/12 for the FROG program to Based on medical record review, facility policy notify all staff members of the review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and revision. This process will also interview, the facility failed to reduce or eliminate be added to the orientation a siderail restraint after multiple falls from the bed program. Upon admission the with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk resident will be placed on the for side rail entrapment for two residents (#18, FROG Program (a frog #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety identifying marker to alert staff devices were on and properly operating for two members that the resident is at residents (#57, #94) two of two residents of ten risk for falls) for 30 days, at the residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of end of the 30 day period the forty-three residents reviewed. resident will be reviewed in the The facility provided a Credible Allegation of Fall Focus Committee consisting Compliance on March 5, 2012. A revisit of the Interdisciplinary Team (not conducted on March 12, 2012, revealed the limited to: Director/Assistant corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Director of Nursing, MDS Non-compliance for F-221 continues at a "E" level Coordinator, Social Services, citation (potential for more than minimal harm). Activity Director). If the resident The findings included: has been free from falls for 30 FORM CMS-2567(02-99) Previous Versions Obsolete days, the resident will be removed Event ID:9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/14/2010 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-039 AND PLAN OF CORRECTION (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (F 323) Continued From page 19 from the program. If the resident HAZARDS/SUPERVISION/DEVICES SS=E {F 323} has experienced a fall in 30 days The facility must ensure that the resident of the initiation of the program, environment remains as free of accident hazards the resident will continue on the as is possible; and each resident receives adequate supervision and assistance devices to program for 30 days (the process prevent accidents. continues until the resident has been free from falls for 30 days). The findings will be documented in the resident's chart by a This REQUIREMENT is not met as evidenced member of the Nursing Based on medical record review, facility policy Administration Staff and review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and communicated to the staff via the interview, the facility failed to reduce or eliminate Care Plan, Nurse Aide a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of Communication Sheet, and the 24 two residents reviewed, failed to identify the risk hour report. for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents 4. (a) The Maintenance Director or reviewed for siderails, failed to assure safety Assistant will bring the Side Rail devices were on and properly operating for two Log to the morning Quality residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to Assurance meeting to discuss any supervise to prevent falls for one resident (#55) of findings related to side rail forty-three residents reviewed. measurements. The The facility provided a Credible Allegation of Administrator or Director of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the Nursing will review the Side Rail corrective actions implemented on March 5, Log daily (Monday-Friday) to 2012, removed the Immediate Jeopardy. ensure the document is completed Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). as needed to reflect the resident's current side rail measurements for The findings included:

Event ID:9D8D12

FORM CMS-2567(02-99) Previous Versions Obsolete

the next 90 days; then weekly for

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED R	
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING		024	R
	ENNESSEE HEALTH		4	REET ADDRESS, CITY, STATE, ZIP COD 465 ISBILL RD MADISONVILLE, TN 37354		12/2012
PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	CHOULDE	(XS) COMPLETE DATE
(F 323) SS≃E	as is possible and	ge 19 VISION/DEVICES sure that the resident as as free of accident hazards each resident receives on and assistance devices to	{F 323}	thereafter. If at any point compliance is not met, the will resume monitoring (Monday-Friday) until compliance is maintained	nt ne party daily d.	
in the second se	Based on medical review, Guidance for Prug Administration) interview, the facility a siderail restraint affective with full side rails in the for side rail entrapmed (#60) of two residents reviewed for siderails devices were on and residents (#57, #94) the facility provided a compliance on March onducted on March on the facility provided a compliance on March onducted on March on the facility provided a compliance on March onducted on March	Credible Allegation of 5, 2012. A revisit 12, 2012, revealed the lemented on March 5, mediate Jeopardy. 221 continues at a "E" level nore than minimal harm).		(b) The Director or Assis Director of Nursing will occurrences daily (Mond Friday) in the morning Q Assurance meeting. The or Assistant Director of N will review all documents all inclusive: Evaluation f use of Side Rails, Pre-Res Physical Restraint Assessing Care Plans, Nurse Event N Investigation, Nurse Aide Communication Sheet, and telephone orders) to ensure are completed as needed as interventions have been implemented and updated resident's care plan for the 90 days; then weekly for 9 if compliance has been maintained; then randomly thereafter. If at any point	review ay- uality Director Jursing s (list not for the straint, ment, Note d e forms and that on the e next O days	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FRIKTED, 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING R B. WING. 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 323} Continued From page 19 compliance is not met, the party (F 323) HAZARDS/SUPERVISION/DEVICES SS=E (the Director or Assistant Director of Nursing) will resume The facility must ensure that the resident environment remains as free of accident hazards monitoring daily (Mondayas is possible; and each resident receives Friday) until compliance is adequate supervision and assistance devices to maintained. The Director or prevent accidents Assistant Director of Nursing will review findings related to the audits in the quarterly QA This REQUIREMENT is not met as evidenced Committee. by: Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate Completion date: 3/22/12 a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for sideralls, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES		1	I CONSTRUCTION 6	(X3) DATE SURVEY		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The Management	LE CONSTRUCTION*	COMPLETED	
VND SFWN O	F CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING		R	
		445457	B. WING	<u> </u>	03/12/2012	
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE			46	EET ADDRESS, CITY, STATE, ZIP CODE 5 ISBILL RD ADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETION	
(F 371) SS≡F	Validation of the Compliance was a record review, revolver, revolver, revolver, revolver, revolver, revolver, revolver, revolver, revolved evand fall risk asses removal of side ralevidence bed zone to reduce or elimin facility provided evand random auditured until it provid correction to incluen sure the deficienthe facility's correction to incluen sure the deficienthe facility's correction to incluen sure the deficienthe facility's correction to incluen sure the deficienthe facility's correction to incluen sure the deficienthe facility recommittee. 483.35(i) FOOD PSTORE/PREPARITHE facility must (1) Procure food ficonsidered satisfacuthorities; and	credible Allegation of accomplished through medical few of facility policy, interview with the nurses, and administrative staff. The ridence of conducting side rail sments for all residents, with fils when indicated, and a measurements were obtained that entrapment risk. The ridence of in-service for all staff is to ensure compliance at a "E" as an acceptable plan of the continued monitoring to an executive measure could be used by the Quality Assurance ROCURE, E/SERVE - SANITARY	{F 371}	F 371 483,35(i) Food Procure Store/Prepare/Serve-Sanitar SS=F Requirement: The facility must: (1) Procure from sources approved or con satisfactory by Federal, State	food sidered o local	
	by:	ENT is not met as evidenced ation and interview, the facility	-	authorities; and (2) store, prep distribute and serve food unde sanitary conditions.	2 12 12 I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION : A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED R 03/12/2012		
	ROVIDER OR SUPPLIER		B, Win	STRE	EET ADDRESS, CITY, STATE, ZIP CODE 5 ISBILL RD	03/1/	32012
EAST TE	NNESSEE HEALTH	*		M	ADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECT	CTION	(X5) COMPLETION
(X4) ID PREFIX TAG	YEARH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
{F 371} {F 406} SS=D	The findings included to the findings included to the dietary deptod carts with food carts with food carts with food carts with food carts with food carts with food carts with food carts with food carts with food carts with food carts with finding at the finding of the first with the first with the first with two plastic places. Interview at the full second pitcher with two plastic places. Interview of the finding of the first with the f	safe food temperatures in the nt. Ided: Interview on February 7, 2012, the Regional Dietary Manager, artment, revealed three metal od trays containing eleven eight milk. The temperature of one as fifty degrees and one glass ar thick) was fifty three degrees. Imme with the Regional Dietary led the safe temperature is forty ower and the milk was at an ure and available for resident. Interview on February 7, 2012, the Dining Room, with the Manager, revealed a metal cart litchers of milk, the first pitcher at forty eight degrees, and the ras one fourth full at forty seven ew at this time with the Regional confirmed the safe temperature less or lower and the milk was at trature and was currently being sidents. IDE/OBTAIN SPECIALIZED		406)	1. Beverages are now being prepared and served at safe temperatures. 2. The Food Service Supervithe temperature of milk producting beverage preparation of 3/15/12 & 3/19/12 with temperaturing in correct range. 3. Dietary staff was in-service 2/7/12 and 3/15/12 by the Foservice Supervisor on the appropriate temperature for the products. 4. The Food Service Supervisor designee will perform randor during meals of prepared bever to ensure appropriate temperature for six (6) we Findings will be discussed in morning QA meeting. Completion date: 3/22/12	ects on eratures ed on od everage sor or on audits verages atures eeks.	
	, Joines in a donner	and a plant of our of the money					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU COMPLE	TED
		445457	B. Wil	NG	•		₹ 2 <u>/2</u> 012
	ROVIDER OR SUPPLIER	CARE	ľ	46	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
	required services fraccordance with §4 provider of specialis. This REQUIREMENT by: Based on medical and interview, the frace of the speech therapy serforty-three resident. The findings includ. Resident #38 was a January 10, 2012, whistory of Stroke wheeling of Stroke with Stroke wheeling of Stro	equired services; or obtain the form an outside resource (in 183.75(h) of this part) from a zed rehabilitative services. NT is not met as evidenced record review, observation, acility failed to provide timely vices for one (#38) of s reviewed. ed: admitted to the facility on with diagnoses including ith Right Leg Weakness, End Stage Dementia, bry of Anxiety, and History of ew of the Physician's dated January 10, 2012, and was to receive a lew of a physician's order 1012, revealed "Speech eval	{F 4	406}	F406 483.45 (a) Provide/Obtain Specialized Rehab Services SS=D Requirement: If specialized rehabilitative sesuch as, but not limited to, phy therapy, speech-language path occupational therapy, and merhealth rehabilitative services from the resident's comprehensive plan of care, the facility must provide the required services, or obtain the required services from an outside resour from a provider of specialized rehabilitative services. Corrective Action Plan: 1. The Speech Language Pathevaluated Resident #38 on and the resident is currently receiving diet as ordered.	ysical nology, ntal for rdation, ne ired d nrcc	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9D8D12

Facility ID; TN6201

PAGE 99/99

A. BUILDING A. BUILDING A. BUILDING A. BUILDING A. BUILDING COMPLETED COMPLETED R O3/12/2012 EAST TENNESSEE HEALTH CARE (X4) ID CARRELL ADDRESS, CITY. STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 PREFIX TAG REGULATORY OR I SC INCHESCION PROVIDER'S PLAN OF CORRECTION A. BUILDING COMPLETED COMPLETED A. BUILDING R WAJ JOATE SURVEY COMPLETED R O3/12/2012 PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION	STATEME AND PLAN	NT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GLIA	-,	10.	FOR	D: 03/14/: M APPRO
Ad5457 B. WMG COFPROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE SYREET ADDRESS, CITY, STATE, ZIP CODE 485 ISBILL RO MADISONVILLE, TN 37354 SECULATORY OR LSC IDEMTRYING INFORMATION) FROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE SYREET ADDRESS, CITY, STATE, ZIP CODE 485 ISBILL RO MADISONVILLE, TN 37354 FROVIDER CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SIBLE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROVIDER SIBLE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FRETY FROM ADISONVILLE, TN 37354 FROM ADISONVILLE, TN 37354 FRO	AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA		IDENTIFICATION NUMBER:			(X3) DATE	SURVEY
EAST TENNESSEE HEALTH CARE SUMMANY STATEMENT OF DEPCEMBLES GOULD PREFIX FROUDER OF ALTHOUGH OF LISC IDENTIFYING INFORMATION) FROUGHT PREFIX FROUGHT OF DEPCEMBLES FROM MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 FROUGHT PROPERTY AND OF CORRECTION FREEW PROPERTY CATTON SIGULD BE CROSS-REFERENCED TO THE OPPROPHANTE DEFICIENCY, FROM TAG COntinued From page 22 must provide the required services; or obtain the required services from an outside resource (In accordance with \$483,75(h) of trap) from a provider of specialized rehabilitative services Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Demenia, Hypertension, History of Anxiety, and History of Depression. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet. Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "Pt (patient) will tolerate LRD (least-restrictive diet) with upgrade trief with SLPP (Speech Language Pathologist) without overt 4/5 STREET ADDRESS CITY, STATE, ZPP CODE MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 27354 EACH CORRECTIVE ACTION SIGULD BE CROSS-REFERENCED TO PREFIX TO SECONS. The From Madison of the PROPARTY TO SECONS. 1. The Frogram Manager or designes will conduct random audits of two (2) patients per week for six (6) weeks			1,000	ACC-02-02-02-02-02-02-02-02-02-02-02-02-02-	NG	COME	LETED
EAST TENNESSEE HEALTH CARE SUMMARY STATEMENT OF DEPICEMPLES PRETY PRETY PRESULTATORY OR LSC IDENTIFYING INFORMATION) (F 408) Continued From page 22 must provide the required services; or obtain the required services from an outside resource (in accordance with \$483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failled to provide timely speech therapy services for one (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertension, History of Anxiety, and History of Depression. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Pure diet. Medical record review of a physician's order dated February 1, 2012, revealed "Speech eval (evaluation) for diet upgrade." Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "Pt (patient) with out stys (signs/symptome) are recorded.	NAME OF	PROVIDER OR SUPPLIER	445457	B. WING_			
MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION REGULATORY OF LOS IDENTIFYING INFORMATION) Department of the provided the required services from an outside resource (in accordance with \$483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertansion, History of Anxiety, and History of Depression. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet. Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "Pt (patient) will tolerate LRD (Speech Language Pathologist) without overt s/s			CARE	ST	REET ADDRESS, CITY, STATE, ZIP COI		12/2012
PROMOBERS PLAN OF CORRECTION PREFIX TAG	(X4) ID	SUMMARY STA	TEMENT OF DESIGNATION				
(F 406) Continued From page 22 must provide the required services; or obtain the required services from an outside resource (in accordance with \$483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertension, History of Anxiety, and History of Depression. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet. Medical record review of a physician's order dated February 1, 2012, revealed "Speech eval (evaluation) for diet upgrade." Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "Pt (patient) will tolerate LRD (Speech Language Pathologist audited telephone orders on 3/9/12 to determine if other residents were affected with no other issues noted. 3. The therapy department was inserviced on 2/29/12 by the Regional Rehab Manager on the Iprocessing therapy referrals. 4. The Program Manager or designee will conduct random audits of two (2) patients per week for six (6) weeks to ensure compliance is maintained. Findings will be discussed in the morning QA meeting. Completion date: 3/22/12 Completion date: 3/22/12		(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID .PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		(X5) COMPLET DATE
must provide the required services; or obtain the required services from an outside resource (in accordance with \$483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed. The findings included: Resident #38 was admitted to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertension, History of Anxiety, and History of Depression. Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet. Medical record review of a physician's order dated February 1, 2012, revealed "Pt (patient) will tolerate LRD (least-restrictive diet) with upgrader trial with St-P (Speech Language Pathologist) without over s/s	{F 406}	Continued From page	Te 22		DEFICIENCY		
(MMO)	Med Add reverse Med (evaluation (Specification (Spe	must provide the recrequired services fro accordance with \$48 provider of specialization. This REQUIREMENT by: Based on medical related interview, the fact speech therapy service orty-three residents related interview and interview in the findings included: the findings incl	quired services; or obtain the om an outside resource (In 83.75(h) of this part) from a sed rehabilitative services. It is not met as evidenced cord review, observation, illity failed to provide timely bes for one (#38) of eviewed. Initied to the facility on a diagnoses including Right Leg Weakness, I Stage Dementia, of Anxiety, and History of the Physician's diagnoses to receive a fa physician's order revealed "Speech evaluade." If the Plan of Treatment tion dated February 5, ient) will tolerate LRD rrupgrade trial with SLP		determine if other residents affected with no other issues 3. The therapy department was serviced on 2/29/12 by the Administrator and on 3/9/12 is Regional Rehab Manager on processing therapy referrals. 4. The Program Manager or designee will conduct random of two (2) patients per week for (6) weeks to ensure compliance maintained. Findings will be discussed in the morning QA meeting.	were noted. vas in- by the the	
	-2567/02-99) Previous Versions Obsolete	· <u> </u>	1		1	- 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/CLIA IDENTIFICATION NUMBER:				UILTIPLE CONSTRUCTION A. LDING	(X3) DATE SURVEY COMPLETED	
		445457	B. WIN	IG	03/12/2012	
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE			·	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION	
{F 406}	Medical record revidated February 10,	age 23 iew of a physician's order 2012, revealed the diet ed to dysphagia (difficult	{F 4	06}		
{F 431} SS=E	chewing) ground. Observation on Fel revealed the SLP for dysphagia mechan potatoes, vegetable. Interview on February with the SLP, in the orders for speech of completed within for the delay in complete ordered on February 2012. 483.60(b), (d), (e) ELABEL/STORE DR	bruary 13, 2012, at 12:40 p.m., eeding the resident a ical diet, of chicken with gravy, es, biscuit, and prune cake. ary 13, 2012, at 12:55 p.m., esmall dining room, revealed evaluations were to be orty-eight hours, and confimed thing the speech evaluation by 1, 2012, until February 5, DRUG RECORDS, UGS & BIOLOGICALS	{F 43	31} F431		
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is r reconciled. Drugs and biological labeled in accordant professional principle appropriate accessor instructions, and the	reploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the ory and cautionary		483.60 (b), (d), (e) Drug R Labels/Store Drugs & Bio SS=E Requirement: The facility must employ of the services of a licensed p who establishes a system of of receipt and disposition of	r obtain harmacist f records f all	
. 1	applicable. In accordance with s	State and Federal laws, the		controlled drugs in sufficier to enable an accurate recon- and determines that drug re	ciliation;	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			_ GMB NO	ir
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	HATAG (BM)	
	1	445457	B. WING _	09/1		
	PROVIDER OR SUPPLIER	CARE	4	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD 1ADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BO	CONTRACTOR
{F 431}	facility must store a locked compartme controls, and perm have access to the The facility must programmently affixed controlled drugs list Comprehensive Dr. Control Act of 1976 abuse, except whe package drug districted.	all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. Tovide separately locked, di compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the prinimal and a missing dose can	{F 431}			
	by: Based on observate and interview, the far narcotics were reconstructed medications medication room and carts. The findings include Observation on Febors the medication rowers (LPN) #8 reverse (LPN) #8 reve	ruary 16, 2012, at 12:45 p.m. om with Licensed Practical ealed the following: 1 box of amine 15mg (milligrams) with ped to the cabinet door bel on the box, and one 10 ml of Trinsulin opened and e refridgerator.		 (a) The Scopolamine patch. Lantus insulin and Novolin R was disposed of following fac policy on 2/16/12 by the Direct Nursing. (b) Narcotic control sheets we reviewed and reconciled as ne on 2/16/12 to show current control the Director of Nursing. All residents receiving a con substance have the potential to affected. No other residents have 	insulin cility ctor of eeded unt by atrolled be	
- 1	nterview with LPN #	8, on February 16, 2012, at				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND LUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED, 03/14/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(52) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY	
		445457	B. WING		R 03/12/2012	
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			REET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION	
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE PROPRIATE	COMPLETION DATE
	insulin had expired. 2012, at 12:45 p.m. in the medication ro Scopolamine patch- cabinet door. Observation on Feb cart #1 at 1:00 pm v ml bottle of Lantus i left available for res 1/12/12. Interview v confirmed the insuli Observation on Feb of medication cart # 10ml bottle Lantus i 1/3/12 with approx 1 with LPN #7 confirm Review of facility po "Routine checks n ensure that expired Review of the Contro Receipt/Record/Disp December 3, 2011 ti revealed, "Morphir (concentrate)(0.25 four hours as neede no reconciliation of to December 3, 2011, to Review of the Contro Review of the Contro Receipt/Record/Disp	Interview on February 16, Interview on February 16, Interview on February 16, Interview on February 16, Interview on February 16, Interview on February 16, Interview on February 16, Interview at this time I	{F 431	narcotic sheets that were not reconciled. 3. Licensed nurses were in-set on 2/17/12, 2/29/12, and 3/15/ the Director of Nursing on the procedure for medication store expiration dates, and reconcilit of controlled drug sheets. 4. The Assistant Director of Nor designee will perform randaudits of the medication carts, medication room, and controlls sheets for compliance for six (weeks. Findings will be report the morning QA meeting. Completion date: 3/22/12	/12 by eage, eation fursing om eled (6)	
	2012, through Janua "Morphine Sulfate-	ry 30, 2012, revealed, 20mg/ml-conc 0.5 ml po/st urther review revealed no	_			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	03/14/2012
FORM.	APPROVED
OMB NO	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A BUILDIN	G	R	
		445457	B. WING_		03/12/2012	
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE			4	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD IADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
{F 441} SS≠F	January 4, 2012 the Review of the policy Accountability Production of each controlled a every shift by the results of each controlled a every shift by the results of each control Review on February phone with the phate the doses remaining correct narcotic control Review of the prevention of the facility must est of disease and infection Control Prevent the facility must est of disease and infection Control The facility must est of disease and infection Control The facility must est program under which (1) Investigates, corring the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to interest the control of the facility of the facility of the facility of the facility; (2) Preventing Spressing Spre	Morphine Sulfate from ough January 30, 2012. y, Controlled Drug edure, revealed "The count substance must be audited urse coming on duty and the v. Both nurses must sign the ecord" ary 17, 2012, at 12:20 p.m., by macy consultant, confirmed g must be entered to verify the ent at the end of the shift. I CONTROL, PREVENT Itablish and maintain an orgam designed to provide a omfortable environment and development and transmission ction. Program tablish an Infection Control ch it - entrols, and prevents infections occurred, such as isolation, an individual resident; and rd of incidents and corrective fections.	{F 431}	F441 483.65 Infection Control, Pr Spread, Linens SS=F Requirement: The facility must establish	and ontrol a safe, ortable ont the	
	(1) When the Infecti determines that a re prevent the spread isolate the resident.	on Control Program sident needs isolation to of infection, the facility must				

FRIKTED: 00/14/2012 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION. (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 03/12/2012 445457 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 'DEFICIENCY) Corrective Action Plan: {F 441} {F 441} Continued From page 27 1. (a) Pill cutters were replaced and (2) The facility must prohibit employees with a the pill crushers were cleaned on communicable disease or infected skin lesions from direct contact with residents or their food, if each of the three (3) med carts on direct contact will transmit the disease. 2/8/12 by the Director of Nursing. (3) The facility must require staff to wash their hands after each direct resident contact for which (b) Resident #111's foot bandage hand washing is indicated by accepted appropriately covered professional practice. was 2/15/12 by the Director of Nursing. (c) Linens Personnel must handle, store, process and 2. (a.) The facility has determined that transport linens so as to prevent the spread of all residents have the potential to be infection. affected. (b) No other residents were uncovered noted with exposed dressings. This REQUIREMENT is not met as evidenced by: 3. Licensed nurses were in-serviced Based on observation and interview the facility on 2/17/12, 2/29/12, and 3/15/12 by failed to maintain sanitary pill cutters/crushers on the Director of Nursing on the three of three medication carts, and the facility failed to ensure infection control measures were protocol for Infection Control to maintained in common areas to prevent the include but not limited to: cleaning spread of infection and prevent potential appropriate of equipment and contamination of a wound for one resident (#111) covering of wounds to prevent the of one random observation.

The findings included:

Observation of medication cart #1, on February 8, 2012, at 9:47 a.m., on the 200 hallway, revealed two pill cutters and the Silent Night pill crusher with debris (pill peices from previous medication preparations) and not maintained in sanitary-condition-for-medication-administration: Interview with Licensed Practical Nurse (LPN) #7 at the time of the observation confirmed the pill cutters and pill crusher were unsanitary.

4. The Assistant Director of Nursing or designee will conduct random rounds to ensure Infection Control Protocol compliance is maintained for six (6) weeks. Findings will be_ reported in the morning QA meeting.

Completion date: 3/22/12

spread of infection.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Fedlity ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FRINTED: 03/14/201-FORM APPROVIDOMB NO. 0938-0301

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION *	(X3) DATE SU COMPLE	
		445457	B. WIN	IG	200 No. 100 No	Name of the Control o	2/2012
	ROVIDER OR SUPPLIER	CARÉ		46	EET ADDRESS, CITY, STATE, ZIP CODE 55 ISBILL RD ADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENCS	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETKIN DATC
{F 441}	Observation of med 2012, at 9:50 a.m., revealed the Silent splattered on the sisanitary condition for Interview with LPN observation, confinunsanitary. Observation of med 2012, at 9:53 a.m., revealed the Silent (liquid oral supplem was not maintained medication administration of the oral supplemedication oral supplemedication	dication cart #2 on February 8, in front of the Nurse's Station, Night pill crusher had blood de and was not maintained in or medication administration. #5, at the time of the med the pill crusher was dication cart #3, on February 8, in front of the Nurse's Station, Night pill crusher had ensurement) and other debris on it and I in sanitary condition for stration. Interview with LPN #6 bservation, confirmed the pill	{F 4	41)			
	revealed resident # near the nurse's sta Observation reveal bandaged left foot a protective footwear Interview with the E the nurse's station, confirmed the resid be covered by som and not resting on the	oruary 15, 2012, at 4:25 p.m, 1111 sitting in a wheelchair ation with other residents. ed the resident had a resting on the tile floor with no in place. Director of Nursing (DON), at at the time of the observation, ent's dressing/bandage should e type of protective footwear the floor uncovered.					
	483.75 EFFECTIVE ADMINISTRATION A facility must be a	RESIDENT WELL-BEING dministered in a manner that resources effectively and	{F 4	90}		V	

FORM CMS-2567(02-99) Provious Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 490} Continued From page 29 {F 490} efficiently to attain or maintain the highest F490 practicable physical, mental, and psychosocial well-being of each resident. 483.75 Effective Administration/Resident Well-Being This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy SS=E review, review of training seminar information, review of Guidance for Industry and FDA (Federal Requirement: Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be A facility must be administered in a administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) manner that enables it to use its were provided a safe enviornment of fourty-three resources effectively and efficiently residents reviewed. The facility's failure to to attain or maintain the highest provide a system to assess for the use of siderails, to reduce or eliminate full siderails to practicable physical, mental, and prevent falls and to reduce the risk of entrapment psychosocial well-being of each placed residents #41, #60, and #18 and any resident. resident who used full side rails, in Immediate Jeopardy. Corrective Action Plan: The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit 1. As of 3/5/12, the facility is conducted on March 12, 2012, revealed the providing a safe environment corrective actions implemented on March 5, through the comprehensive 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level assessment of each resident to meet citation (potential for more than minimal harm). the resident's needs and maintaining their optimal physical, mental and The findings included: psychosocial well being. Validation of the Credible Allegation of Compliance-was-accomplished-through-medical-(a) Upon review of the Fall Risk record review, review of facility policy, Assessment on 2/6/12 completed by observation, and interview with the nurses, the licensed nurse the systematic nursing assistants, and administrative staff. The review of risk factors indicated a risk

Event 10:908012

Facility ID: TN6201

EAST TN HEALTH CARE

DEPARTMENT	OF HEAD	714	AND HUMAN	SERVICES
OCKITEDO FOR				

PRINTED: 03/14/201: FORM APPROVEE

	NT OF DEFICIENCIES	* & MEDICAID SERVICES	,		OMB NO. 0938-039
AND PLAN	OF CORRECTION	(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		445457	B. WING_		R 03/12/2012
l	PROVIDER OR SUPPLIER ENNESSEE HEALTH	CARE	'	REET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354	00/12/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	efficiently to attain or practicable physical well-being of each well-being of each by: This REQUIREMENT by: Based on medical review, review of traceview of Guidance Drug Administration observation, and intadministered in a machinistered i	or maintain the highest I, mental, and psychosocial resident. It is not met as evidenced record review, facility policy alining seminar information, for Industry and FDA (Federal) staff, dated 2006, erview, the facility failed to be anner to ensure seven #18, #55, #94, #57, #83) e enviornment of fourty-three The facility's failure to assess for the use of or eliminate full siderails to reduce the risk of entrapment I, #60, and #18 and any Ill side rails, in Immediate a Credible Allegation of h 5, 2012. A revisit 12, 2012, revealed the plemented on March 5, nmediate Jeopardy. F-221 continues at a "E" level more than minimal harm).	(F 490)	score of 24 (high risk) for resident #41. Based on the risk factors in his Fall Risk Assessment it was determined that he was not a candidate for the use of side rail to impaired judgment, incontine and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Direct The nursing administration staff communicated changes made to resident's plan of care (removal side rails and low bed with one in to the direct caregivers on the Nu Aide Communication Worksheet the Care plans on 2/6/12. On 2/1 a telephone order was obtained by the charge nurse and the Director Nursing to discontinue the resident bed and chair alarm and use a sempressure pad for his bed and chair. The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident care plan was updated on 2/24/12 the Interim MDS Coordinator to	ent from Is due ence, ctor. the of nat) rise and 7/12 y of at's sor I he
	ecord review, review observation, and internution, and internution, and internution, and internution assistants, and	mplished-through madical		reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:908012

Facility ID: TN6201

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2011 FORM APPROVEE OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445457	B. WING		R 03/12/2012
	PROVIDER OR SUPPLIER	CARE		REET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354	
(X4) ID PREFIX TAG	(EAGH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
	practicable physical welf-being of each welf-being of each welf-being of each welf-being of each welf-being of each by: Based on medical review, review of traceiew, review of traceiew of Guidance Drug Administration observation, and invadministered in a machinistered in a machi	or maintain the highest of maintain the highest of mental, and psychosocial resident. NT is not met as evidenced record review, facility policy aining seminar information, of or Industry and FDA (Federal n) staff, dated 2006, terview, the facility failed to be manner to ensure seven to ensure seven to ensure seven the facility's failure to eassess for the use of the enviornment of fourty-three. The facility's failure to eassess for the use of the enviornment of entrapment to reduce the risk of entrapment to eassess for the use of the enviornment of entrapment to easy for the use of the enviornment of entrapment to easy for the use of the enviornment of entrapment to easy for eliminate full siderails to reduce the risk of entrapment to entrapment to entrapment to entrapment the entrapment of the enviornment of the envisit of the enviornment of entrapment than minimal harm). d: dible Allegation of complished-through-medical—vior facility policy, erview with the nurses, and administrative staff. The	(F 490)	needed, family at bedside sest throughout the day, get patie when trying to get out of bed snacks, attempt to keep reside or clean immediately after incontinent episode). The cawas audited by the Nursing Administration Staff (Direct Nursing, Staffing Coordinator) to ethat the plan of care had been updated to reflect the resident current status on 2/24/12. Rewas hospitalized from 2/24/13/3/2/12, returning with a chang medical status. The Fall Risk Assessment updated on 3/5/12 Director of Nursing reflects the resident no longer attempts to transfer, requiring assistance of transfers. The resident no longer equires constant supervision in prevention of falls. He is on the FROG Program that provides observation from various staff members. Resident was transfer to the hospital again on 3/9/after visit by attending physis MDS Coordinator complete.	ssions nt up l, offer ent dry re plan or of ator, ensure t's sident 2 to ge in 2 by the nat self of 2 for ger for the he closer

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTLD: 03/14/2010

DEPARTMENT OF HEALTH AND HOMALI SURVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND FLAN OF CORRECTION COMPLETED A. BUILDING B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 490} Continued From page 29 {F 490} discharge assessment on 3/9/12. efficiently to attain or maintain the highest practicable physical, mental, and psychosocial Resident was readmitted on well-being of each resident. 3/15/12 with admitting Charge Nurse completing Fall Risk This REQUIREMENT is not met as evidenced Assessment and Evaluation for the Use of Side Rails with the Based on medical record review, facility policy review, review of training seminar information, recommendation to be that side review of Guidance for Industry and FDA (Federal rails were not indicated at that Drug Administration) staff, dated 2006. time. Resident's care plan was observation, and interview, the facility failed to be administered in a manner to ensure seven updated on 3/21/12 with a residents (#41, #60, #18, #55, #94, #57, #83) significant change assessment. were provided a safe environment of fourty-three residents reviewed. The facility's failure to Resident's care plan is updated provide a system to assess for the use of per MDS and/or Charge Nurse on siderails, to reduce or eliminate full siderails to ongoing bases and as needed with prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any any new orders, interventions, or resident who used full side rails, in Immediate changes. Jeopardy. The facility provided a Credible Allegation of (b) Resident #18 The side rails that Compliance on March 5, 2012. A revisit were in place during the survey were conducted on March 12, 2012, revealed the immediately changed to full anticorrective actions implemented on March 5, entrapment rails on 2/6/12 by the 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level Maintenance Director after receiving citation (potential for more than minimal harm). a physician's order. The measurements for the bed zones were The findings included: obtained by the Maintenance Validation of the Credible Allegation of Director on 2/6/12 using a standard Gempliance was accomplished through medical tape measure with measurements. record review, review of facility policy, The Staffing Coordinator wrote a observation, and interview with the nurses, nursing assistants, and administrative staff. The narrative note in the nurses notes on 2/6/12 describing the resident with

Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRIMILE; 03/14/201 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDI EISUPPLIERICLIA AND FLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY COMPLETED A BUILDING 445457 B. WING NAME OF PROVIDER OR SUPPLIER R 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 490} Continued From page 29 efficiently to attain or maintain the highest (F 490) limited functional status using the practicable physical, mental, and psychosocial side rails as a restraint. A Physical well-being of each resident. Restraint Assessment was updated on 2/6/12 for the use of side rails. A This REQUIREMENT is not met as evidenced Side Rail Assessment and Informed Consent was signed by the family on Based on medical record review, facility policy 2/13/12. On 2/20/12 the MDS review, review of training seminar information, review of Guidance for Industry and FDA (Federal Coordinator completed an Evaluation Drug Administration) staff, dated 2006, for use of Side Rails with a reduction observation, and interview, the facility failed to be in side rails from full (antiadministered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) entrapment) to 1/2 rails, the physician were provided a safe environment of fourty-three was notified and order was obtained residents reviewed. The facility's failure to for 1/2 rails. The measurements for the provide a system to assess for the use of siderails, to reduce or eliminate full siderails to bed zones were obtained by the prevent falls and to reduce the risk of entrapment Maintenance Director on 2/20/12. placed residents #41, #60, and #18 and any On 2/23/12 the resident was resident who used full side rails, in Immediate evaluated again for side rail Jeopardy. reduction by the Staffing The facility provided a Credible Allegation of Coordinator, the resident's side rails Compliance on March 5, 2012. A revisit was eliminated and the resident was conducted on March 12, 2012, revealed the corrective actions implemented on March 5, placed on a low bed with mats. The 2012, removed the Immediate Jeopardy. Physical Restraint Assessment was Non-compliance for F-221 continues at a "E" level completed on 2/28/12 by the Staffing citation (potential for more than minimal harm). Coordinator for the elimination of The findings included: side rails and the use of a low bed with mats after receiving a Validation of the Credible Allegation of physician's order. The care plan Gempliance was accomplished through medical was audited by the Nursing record review, review of facility policy, observation, and interview with the nurses, Administration Staff to ensure that nursing assistants, and administrative staff. The the plan of care had been updated to reflect the resident's current status on FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12 Facility ID: TN6201 If continuation sheet Page 30 of 38

FORM CMS-2567(02-99) Previous Versions Obsolete

4234424465 PAGE 99/99 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTLE: 03/14/20 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVE AND FLAN OF CORRECTION OMB NO. 0938-03! (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED B. WING NAME OF PROVIDER OR SUPPLIER 445457 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} 2/29/12. . On 3/5/12 resident practicable physical, mental, and psychosocial rolled out of bed with a small well-being of each resident. laceration to upper lip with intervention to check placement This REQUIREMENT is not met as evidenced of furniture and remove if in Based on medical record review, facility polic pathway. Keep room free of review, review of training seminar information, clutter for safety, Bowel and review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, bladder program to determine observation, and interview, the facility failed to be habit time, and Falls Reduced Our administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) Goal, FROG Program. Care plan were provided a safe environment of fourty-three was updated to reflect new residents reviewed. The facility's failure to interventions for 3/5. 3/13 provide a system to assess for the use of siderails, to reduce or eliminate full siderails to resident was found in room 129 prevent falls and to reduce the risk of entrapment bathroom with one shoe on. placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Resident had gotten up from her Jeopardy. wheel chair in another resident's room, with interventions for The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit proper footwear (nonskid) replace conducted on March 12, 2012, revealed the footwear when resident removes corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. as allows with physical therapy to Non-compliance for F-221 continues at a "E" level screen. On 3/15, further citation (potential for more than minimal harm). intervention was added to get up The findings included: after breakfast as desires after further investigation of fall on Validation of the Credible Allegation of 3/13. Fall on 3/17 where resident Gempliance was accomplished through medicalrecord review, review of facility policy, rolled from the bed in her sleep, observation, and interview with the nurses, bed was in lowest position with nursing assistants, and administrative staff. The

Event 10:908012

If continuation sheet Page 30 of 38

mats on both sides, no injury

Facility ID: TN6201

DEFARTMENT OF HEALTH AND HUMAN SERVICES

PRINTLE: 03/14/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	RE & MEDICAID SERVICES		24.2		APPROVE 0. 0938-039
STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE S	SURVEY
	445457	B, WING_	······································	03/1	12/2012
NAME OF PROVIDER OR SUPPLIES EAST TENNESSEE HEALTH	3.	4	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD MADISONVILLE, TN 37354	•	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
This REQUIREME by: Based on medica review, review of Guidance Drug Administration observation, and in administered in a residents (#41, #60 were provided a saresidents reviewed provide a system to siderails, to reduce prevent falls and to placed residents #4 resident who used Jeopardy. The facility provided Compliance on Marconducted on Marconducted on Marconducted on Marconducted on Corrective actions in 2012, removed the Non-compliance for citation (potential for The findings included Validation of the Crecompliance-was-accord review, review observation, and into the Crecompliance on the	or maintain the highest al, mental, and psychosocial resident. ENT is not met as evidenced record review, facility policy raining seminar information, for Industry and FDA (Federal n) staff, dated 2005, atterview, the facility falled to be manner to ensure seven 0, #18, #55, #94, #57, #83) after environment of fourty-three. The facility's failure to assess for the use of or eliminate full siderails to reduce the risk of entrapment al., #60, and #18 and any full side rails, in Immediate If a Credible Allegation of the 5, 2012. A revisit hid 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level of the more than minimal harm).	{F 490}	noted, intervention to add noodles to define perimeter bed with all above intervent added to the care plan as implemented. Resident's or plan is updated per MDS at Charge Nurse on an ongoin bases and as needed with an orders, interventions, or charge interventions, or charge in place during the survering immediately changed to full at entrapment rails (prior to the entrapment rails (prior to the entrapment rails (prior to the entrapments for the bed zone obtained by the Maintenance Director. The measurements for the bed zone obtained by the Maintenance Director on 2/6/12 using a stantape measure. The Side Rail Assessment and Informed Construction form (one form) was later comby the Staffing Coordinator on 2/6/12 for the use of side rails to side rails after receiving a physician's order for the use of rails by the Staffing Coordinator (after the exit of the surveyors for evening) that were changed out	er of the ntions care nd/or ng ny new anges. cils that by were nti- exit of e es were dard sent pleted vith a ½ nor the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVE

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTLD: 03/14/261 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING R

	j.	- 10	ILDING .	COMP	LETED
NAME OF PROVIDER OR SU	445457	B. WII	4G		R
EAST TENNESSEE HE			STREET ADDRESS, CITY, STATE, ZIP C	03/	12/2012
			MADISONVILLE, TN 37354		
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC (DENTIFYING	ID			
IAG REGULATO	RY OR LSC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
(F 490) Continued Fr efficiently to a	offsin on materials and	{F 49	the Maintenance Director	The best	
Well-heing of	nysical, maintain the highest nysical, mental, and psychosocial		Zone measurements war	. The bed	1
rion being of	each resident.	1	zone measurements were the Maintenance Director	obtained by	
		İ	A Pre-Restmint A	on 2/6/12.	i
This REQUIR	EMENT is not met as evidenced	· 1	A Pre-Restraint Assessme	ent was	
Dy:	sevidenced	1	completed on 2/21/12 by	the Staffing	
review review	dical record review, facility policy		Coordinator that indicated	d side rails	
review of Guid	ance for ladest		being used as a restraint a	nd assisting	
Drug Administ	ration) staff, dated 2006,	ral	the resident. Resident w	as	81
		_ [transferred to hospital o	n 2/26/12	
administered in	a manner to ensure seven	e	The Interim MDS Coord	linator	
			completed a Discharge		
residents review	wed. The facility of fourty-three	e	Assessment on 2/29/12		
provide a syste	to come a facility's failure to	1	reflected the see S : 1	which	
siderails, to red	uce or eliminate full sideralis to	1	reflected the use of side	rails as a	
pievent talls an	d to reduce the risk of entrapmen	t l	restraint (as ½ rails were	used	
resident who us	a to reduce the risk of entrapmen s #41, #60, and #18 and any ed full side rails, in Immediate		until 2/23/12 during the	7 day	
Jeopardy.	ed foil side rails, in Immediate	1	look back period). The r	esident	
Th			was reassessed upon retur	to the	
Compliance -	ded a Credible Allegation of	1 1	facility on 3/12/12 by the		
conducted on Ma	arch 12, 2012. A revisit	1 1	admitting Charge Nurse v	ا ماند	
corrective action	s implemented on March 5,	1 1	completed an Evaluation	vuo	
2012, removed to	ne Immediate Jeopardy.	1 1	use of Side Date	tor the	
citation (-	for F-221 continues at a "E" level		use of Side Rails and a Fa	II Risk	
(potential	for more than minimal harm).		Assessment with the		
The findings inclu	ided:	1 1	recommendation for no sig	le rails	
4			indicated at this time. The	MDS	
Validation of the	redible Allegation of		Coordinator completed a 5	day	
record saving	stedible Allegation of accomplished through medical—		Readmission Assessment	uay	
observation and	iew of facility policy, nterview with the nurses,		3/22/12. (A 14 day Assess	n [
		· .	XA. IA 14 DAV A CCADE	mont	
HUISING ASSISTANTS	, and administrative staff. The		was completed on 3/29/12)	metir	

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRINTED: 03/14/20 STATEMENT OF DEFICIENCIES FORM APPROVI (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-03 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445457 NAME OF PROVIDER OR SUPPLIER R 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL MADISONVILLE, TN 37354 (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} Resident's care plan is updated practicable physical, mental, and psychosocial well-being of each resident. per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, This REQUIREMENT is not met as evidenced interventions, or changes. by: Based on medical record review, facility policy review, review of training seminar information, (d) Resident # 57 A telephone order review of Guidance for Industry and FDA (Federal was received from the resident's Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be physician for the use of 1/2 side rails administered in a manner to ensure seven on 2/10/12. The resident was residents (#41, #60, #18, #55, #94, #57, #83) assessed on 2/20/12 using the were provided a safe environment of fourty-three Evaluation for use of Side Rails (for residents reviewed. The facility's failure to provide a system to assess for the use of the evaluation of side rail use) siderails, to reduce or eliminate full siderails to indicating the use of 1/2 side rails by prevent falls and to reduce the risk of entrapment the Staffing Coordinator. A Preplaced residents #41, #60, and #18 and any resident who used full side rails, in Immediate Restraint Assessment was completed Jeopardy. on 2/21/12 by the Director of Nursing that indicated side rails are The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit used as a restraint. On 2/24/12 conducted on March 12, 2012, revealed the another Evaluation for the use of corrective actions implemented on March 5, Side Rail was completed by the 2012, removed the Immediate Jeopardy. Staffing Coordinator indicating the Non-compliance for F-221 continues at a "E" level elimination of 1/2 side rails (no side citation (potential for more than minimal harm). rails are in place at this time). As of The findings included: 2/24/12 the resident's current interventions include: the locking of Validation of the Credible Allegation of wheel chair prior to transfer, offer Gompliance was accomplished through medicalrecord review, review of facility policy, rest periods, assist to the bathroom observation, and interview with the nurses, during rounds and as needed, bed in nursing assistants, and administrative staff. The lowest position, a chair sensor pad. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 908012 Facility ID: TN6201 If continuation sheet Page 30 of 38

DEFARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES PRINTED 03/14/201 FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB_NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY COMPLETED A. BUILDING 445457 B. WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} The care plan was audited by the practicable physical, mental, and psychosocial Nursing Administration Staff to well-being of each resident. ensure that the plan of care had been 4 updated to reflect the resident's This REQUIREMENT is not met as evidenced current status on 2/29/12. The care by: plan was audited by the Nursing Based on medical record review, facility policy review, review of training seminar information. Administration Staff to ensure that review of Guidance for Industry and FDA (Federal the plan of care had been updated to Drug Administration) staff, dated 2006 reflect the resident's current status on observation, and interview, the facility failed to be 2/29/12. The resident's care plan administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) was reviewed by the Director of were provided a safe environment of fourty-three Nursing on 3/7/12 and evaluated for residents reviewed. The facility's failure to fall prevention strategies and deemed provide a system to assess for the use of siderails, to reduce or eliminate full siderails to the intervention for constant prevent falls and to reduce the risk of entrapment supervision during toileting was placed residents #41, #60, and #18 and any inappropriate. After review of resident who used full side rails, in Immediate current interventions on 3/7/12 by Jeopardy. the Director of Nursing and further The facility provided a Credible Allegation of investigation of the incident (with Compliance on March 5, 2012. A revisit intervention not to leave unattended) conducted on March 12, 2012, revealed the corrective actions implemented on March 5, it was determined that the 2012, removed the Immediate Jeopardy. intervention was implemented before Non-compliance for F-221 continues at a "E" level a full root cause analysis was citation (potential for more than minimal harm). conducted (the intervention was removed as of 2/24/12 interventions The findings included: above). As of 3/22/12, current Validation of the Credible Allegation of interventions, the resident remains on Gempliance was accomplished through medical the FROG (Falls Reduced Our Goal) record review, review of facility policy, observation, and interview with the nurses, program, participates in restorative nursing assistants, and administrative staff. The with ambulation "walk to dine program", low bed with mats, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9D8D12 Facility ID: TN6201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION (X3) DAT	RM AP <u>NO. 09</u>
NAME OF PROVIDER OR SUPPLIER	445457	B. WING		R
EAST TENNESSEE HEALTH	CARE	\$	TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD	3/12/2
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR L:	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION	COI
F 490} Continued From page efficiently to attain of practicable physical, well-being of each result well-being of each result provided a fer review, review of trainsteries of Guidance for Drug Administration) observation, and interested in a markesidents (#41, #60, #were provided a safe residents reviewed. The provide a system to assiderails, to reduce or prevent falls and to reciplaced residents #41, resident who used full Jeopardy. The facility provided a Compliance on March 12 corrective actions imple 2012, removed the Immon-compliance for F-2 citation (potential for moduced in the findings included: Validation of the Credibile Compliance-was-accomprecord review, review of observation, and intention of the credibile compliance and intention of the credibile compliance and intention of the credibile compliance and intention of the credibile compliance and intention of the credibile compliance was-accomprecord review, review of observation, and intention of the credibile compliance and intention of the credibile compliance was-accomprecord review, review of observation, and intention of the credibile compliance was-accomprecord review, review of observation, and intention of the credibile compliance was-accomprecord review, review of observation, and intention of the credibile compliance was-accomprecord review, review of observation and intention of the credibile compliance was-accomprecord review, review of observation and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile compliance was accompressed and intention of the credibile complex compressed and intention of	r maintain the highest mental, and psychosocial esident. It is not met as evidenced accord review, facility policy ning seminar information, or Industry and FDA (Federal staff, dated 2006, view, the facility failed to be nner to ensure seven 18, #55, #94, #57, #83) enviornment of fourty-three he facility's failure to essess for the use of eliminate full siderails to duce the risk of entrapment #60, and #18 and any side rails, in Immediate Credible Allegation of 5, 2012. A revisit 1, 2012, revealed the mented on March 5, rediate Jeopardy. 21 continues at a "E" level one than minimal harm).	{F 490}	DEFICIENCY)	COI

04/02/2012 08:11

DEPARTMENT OF REALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTEL: 03/14/2012 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B, WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (XS) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} from rolling providing the resident practicable physical, mental, and psychosocial with stability. An identifier with the well-being of each resident. resident's name was attached to the wheel chair on 2/29/12. The This REQUIREMENT is not met as evidenced resident's care plan was reviewed by: and updated by the Director of Based on medical record review, facility policy review, review of training seminar information, Nursing on 2/29/12 to reflect the review of Guidance for Industry and FDA (Federal resident's current status. After Drug Administration) staff, dated 2006, review of current interventions on observation, and interview, the facility failed to be administered in a manner to ensure seven 3/7/12 by the Director of Nursing residents (#41, #60, #18, #55, #94, #57, #83) and further investigation of the were provided a safe environment of fourty-three incident (with intervention not to residents reviewed. The facility's failure to provide a system to assess for the use of leave unattended was not siderails, to reduce or eliminate full sideralls to identified as an appropriate prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any intervention to prevent falls). The resident who used full side rails, in Immediate resident remains on the FROG Jeopardy. program and does not require The facility provided a Credible Allegation of constant supervision, further Compliance on March 5, 2012. A revisit monitoring and interventions will conducted on March 12, 2012, revealed the corrective actions implemented on March 5, continue to prevent falls. Resident 2012, removed the Immediate Jeopardy. had fall on 3/21/12 from the bed Non-compliance for F-221 continues at a "E" level while attempting to get urinal that citation (potential for more than minimal harm). had fallen in the floor. After The findings included: Event Note review and Validation of the Credible Allegation of occurrence investigation Compliance-was-accomplished-through-medicalcompleted with the intervention to record review, review of facility policy, place urinal within reach and observation, and interview with the nurses, nursing assistants, and administrative staff. The apply nonskid socks. In addition, intervention was added 3/30 to FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SURVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED :: 03/14/2011 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/GUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (XX) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445457 B, WING NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 490} | Continued From page 29 efficiently to attain or maintain the highest {F 490} attach personal item bag to head practicable physical, mental, and psychosocial of bed to place urinal in for well-being of each resident. resident's access. No other changes have been indicated. This REQUIREMENT is not met as evidenced Resident's care plan is current Based on medical record review, facility policy and updated per MDS and/or review, review of training seminar information, review of Guidance for Industry and FDA (Federal Charge Nurse on an ongoing Drug Administration) staff, dated 2006, bases and as needed with any new observation, and interview, the facility failed to be orders, interventions, or changes. administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe environment of fourty-three (f) Resident #55 care plan was residents reviewed. The facility's failure to reviewed and modified on 2/14/12 provide a system to assess for the use of by the MDS Coordinator and siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment reflected the resident's current placed residents #41, #60, and #18 and any status. No further assessments could resident who used full side rails, in Immediate be completed due to the resident Jeopardy. expiring on 2/16/12. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit (g) Resident #83 The conducted on March 12, 2012, revealed the corrective actions implemented on March 5, recapitalization orders were 2012, removed the Immediate Jeopardy signed by the physician for 2/2/12 Non-compliance for F-221 continues at a "E" level included an order for the use of citation (potential for more than minimal harm). side rails. An assessment was The findings included: completed on 2/6/12 using a Pre-Validation of the Credible Allegation of Restraint Assessment for the use Gempliance-was-accomplished-through-medicalof 34 side rails completed by the record review, review of facility policy, MDS Coordinator indicating a observation, and interview with the nurses, nursing assistants, and administrative staff. The restraint was recommended related to cognitive impairment, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12 Fadility ID: TN6201

DEFARTMENT OF REALTH AND RUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRHVII. : 03/14/20 STATEMENT OF DEPICIENCIES FORM APPROVE (X1) PROVIDER/GULPLILR/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} requiring physical assistance, and practicable physical, mental, and psychosocial unaware of safety issues. On well-being of each resident. 2/20/12 an Evaluation for the use of Side Rail Assessment was This REQUIREMENT is not met as evidenced completed by the MDS by: Based on medical record review, facility policy Coordinator indicating the review, review of training seminar information, resident was unaware of safety review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, needs, cognitive impairment, and observation, and interview, the facility failed to be requiring physical assistance administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) utilizing 3/4 side rails. A new were provided a safe enviornment of fourty-three Evaluation for the use of Side residents reviewed. The facility's failure to Rails was completed on 2/23/12 provide a system to assess for the use of siderails, to reduce or eliminate full siderails to by the Director of Nursing for the prevent falls and to reduce the risk of entrapment reduction of side rails from 3/4 to placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate 1/2. The resident's Physical Restraint Assessment was updated on 2/23/12 by the The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit Director of Nursing for the conducted on March 12, 2012, revealed the restraint reduction and new orders corrective actions implemented on March 5, received for the use of 1/2 side 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level rails. On 2/28/12, an Evaluation citation (potential for more than minimal harm). for the use of Side Rails and The findings included: Physical Restraint Assessment was completed by the Director of Validation of the Credible Allegation of Nursing indicating the elimination Gempliance-was-accomplished-through medical record review, review of facility policy, of 1/2 rails and placed on low bed observation, and interview with the nurses, with mats. The care plan was nursing assistants, and administrative staff. The audited by the Nursing FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 908012

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICE: CENTERS FOR MEDICARE & MEDICARD SERVICES PRINTLE: 03/14/26 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDERAGINELIER/CLIA AND FLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED 445457 B. WING NAME OF PROVIDER OR SUPPLIER R 03/12/2012 EAST TENNESSEE HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL 10 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} Administration Staff to ensure practicable physical, mental, and psychosocial that the plan of care had been well-being of each resident. updated to reflect the resident's current status on 2/29/12. Care This REQUIREMENT is not met as evidenced plan is current to resident's status by: Based on medical record review, facility policy and is updated per MDS and/or review, review of training seminar information, Charge Nurse on an ongoing review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, bases and as needed with any new observation, and interview, the facility failed to be orders, interventions, or changes. administered in a manner to ensure seven 2. (a) The Nursing Administration residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe environment of fourty-three Staff(Director of Nursing, MDS residents reviewed. The facility's failure to Coordinator, and Staffing provide a system to assess for the use of Coordinator) reviewed all siderails, to reduce or eliminate full siderails to residents using side rails, and the prevent falls and to reduce the risk of entrapment resident's individual fall risk placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate assessment scores to identify Jeopardy. those that may be at risk for injury, and assessing and coding The facility provided a Credible Allegation of the resident's assessment Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the correctly. Residents using side corrective actions implemented on March 5, rails as a restraint were identified 2012, removed the Immediate Jeopardy. and care planned accordingly. A Non-compliance for F-221 continues at a "E" level comprehensive assessment was citation (potential for more than minimal harm). completed; interventions were The findings included: modified as needed and placed on the individuals care plan. The Validation of the Credible Allegation of Administration Team Gompliance was accomplished through medical-(Administrator, Director of record review, review of facility policy, Nursing, and Assistant Director of observation, and interview with the nurses, nursing assistants, and administrative staff. The Nursing, Maintenance Supervisor, Social Services/Admissions FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12 Facility ID: TN6201 If continuation sheet Page 30 of 38

DEFARTMENT OF HEALTH AND HUMAN SERVICES

VIAD STAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDERICATION NUMBER.	(X3) MU	TIPLE CONSTRUCTION	OMB N	M APPRI 0. 0938
		1	A. BUILD	ING	COME	LETED
NAME OF	PROVIDER OR SUPPLIER	445457	B. WING			R
		-			03/	12/2012
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	,	REET ADDRESS, CITY, STATE, ZIP GODE 465 ISBILL RD MADISONVILLE, TN 37354		12/2012
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRI		COMPLE DATE
The Concitat The Valid Germ record observations of the Concident of the Concident observations observations observa	This REQUIREMENT by: Based on medical receive, review of train eview of Guidance for Orug Administration) sibservation, and intendiministered in a man esidents (#41, #60, #/ ere provided a safe esidents reviewed. The ovide a system to asside a system to asside to reduce or elevent falls and to reduce or elevent falls and to reduce or esidents who used full sident who used full sopardy. The facility provided a Compliance on March 12, rective actions impler 2, removed the Immediaced on potential for more findings included: dation of the Credible apliance was accompliance for F-22 function, and interesting and review, review of far and interesting	maintain the highest mental, and psychosocial sident. is not met as evidenced cord review, facility policy ing seminar information, r Industry and FDA (Federal staff, dated 2006, view, the facility failed to be ner to ensure seven 18, #55, #94, #57, #83) inviornment of fourty-three ne facility's failure to sess for the use of eliminate full siderails to uce the risk of entrapment 60, and #18 and any ide rails, in Immediate redible Allegation of 2012. A revisit 2012, revealed the mented on March 5, ediate Jeopardy. It continues at a "E" level e than minimal harm). Allegation of ished-through-medical acility policy, with the nurses, iministrative staff. The	E R TI A Cus As Foot	DETICIENCY)	Food ail of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FRUVII. . 02/14/20 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA FORM APPROV AND PLAN OF CORRECTION OMB NO. 0938-03 IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445457 B. WING R EAST TENNESSEE HEALTH CARE 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES MADISONVILLE, TN 37354 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEN FYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 490} Continued From page 29 efficiently to attain or maintain the highest {F 490} determine if side rails were practicable physical, mental, and psychosocial needed and/or could be reduced; well-being of each resident. notification of family and/or resident of the use of side This REQUIREMENT is not met as evidenced rails/restraints, to determine if a Based on medical record review, facility policy restraint was recommended, and review, review of training seminar information, to review the resident for possible review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, reduction of a restraint. The Preobservation, and interview, the facility failed to be Restraint Assessment was administered in a manner to ensure seven completed for residents using side residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe environment of fourty-three rails as restraints to assess residents reviewed. The facility's failure to residents using side rails to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to determine if side rails were prevent falls and to reduce the risk of entrapment recommended as a restraint on placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate 2/28/12 by the Nursing Administration Team, with findings documented on the The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit resident's individual assessment conducted on March 12, 2012, revealed the form (Side Rail Assessment and corrective actions implemented on March 5, Informed Consent Form, 2012, removed the Immediate Jeopardy Non-compliance for F-221 continues at a "E" level Evaluation for the use of Side citation (potential for more than minimal harm). Rails, Pre-Restraint Assessment The findings included: and/or the Physical Restraint Assessment). Through the Validation of the Credible Allegation of individual resident assessment Gempliance was accomplished through medicalrecord review, review of facility policy, and monitoring of side rail use, observation, and interview with the nurses, the facility has been able to nursing assistants, and administrative staff. The reduce the use of side rails with a ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9D8D12 Facility ID: TN6201 If continuation sheet Page 30 of 38

		AND TRUMAN SET VICES				PRIM	Lii: 03/14/20
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	MULTI	PLE CONSTRUCTION	OMB (X3) DAT	NO. 0938-039 NO. 0938-039
		445.55	A. BUI			COV	MPLETED
NAME OF	PROVIDER OR SUPPLIER	445457	B, WIN	^{IG} _			R
	ENNESSEE HEALTH C	ADC		STRE	SET ADDRESS, CITY, STATE, ZIP CODE	1 0.	3/12/2012
			1	40	a ISBILL RD		
(X4) ID PREFIX TAG	SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX	1	ADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTE CROSS PEEPERSON	44	COMPLETION
			IAG	-	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
The Val	efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on medical review of Guidance for Drug Administration) subservation, and interestive of Guidance in a manufacture of Guidance	maintain the highest mental, and psychosocial sident. is not met as evidenced cord review, facility policy ing seminar information, r Industry and FDA (Federal staff, dated 2006, view, the facility failed to be mer to ensure seven 18, #55, #94, #57, #83) enviornment of fourty-three he facility's failure to sess for the use of eliminate full siderails to luce the risk of entrapment (60, and #18 and any side rails, in Immediate Credible Allegation of 5, 2012. A revisit 2012, revealed the mented on March 5, ediate Jeopardy. 21 continues at a "E" level re than minimal harm).	{F 49	i i i i i i i i i i i i i i i i i i i	current total of 4 residents (rails). Side rails that were reduced or removed by the Maintenance Director based the resident's individual assessment results by nurse administration beginning on 2/6/12 through 2/29/12. The Maintenance Director and the Maintenance Assistant obtains measurements of all remaining side rails using a standard tape measure. Measurements were obtained with the bed in a flat articulated position. All finding the FDA recommendation referenced in the FDA Hospita Bed System Dimensional and Assessment Guidance to Reduce the FDA economendations were replaced as needed with anti-entrapment alls, shorter side rails (1/4, ½, and 3/4) or eliminated as needed	on ed g and ngs s as d	
reco	ord review, review of the review of the review and interview	dished-through medical—		b	ased on the resident's individu ssessments and/or for non-use	ıal	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

DEPARTMENT OF HEALTH AND HUMAN OF RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION

	FORM APPROVE
(X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-039
A. BUILDING	(X3) DATE SURVEY COMPLETED
B. WING	R

	1	A. BUILDIN	G	COMPLETE	ED
NAME OF PROVINCE	445457	B. WING_		R	250
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH (1 46	GET ADDRESS, CITY, STATE, ZIP CC	03/12/	2012
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ADISONVILLE, TN 37354 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	CHALLE	(X5)
This REQUIREMENT by: Based on medical review, review of train review of Guidance for Drug Administration): observation, and internation administered in a mark residents (#41, #60, # were provided a safe of residents reviewed. The provide a system to assideralls, to reduce or prevent falls and to reciplaced residents #41, # resident who used full a Jeopardy. The facility provided a Compliance on March to conducted on March 12 corrective actions imple 2012, removed the Imm Non-compliance for F-2 citation (potential for mother than the conducted on March 12 corrective actions included: Validation of the Credible Validation of the Credi	r maintain the highest mental, and psychosocial esident. It is not met as evidenced ecord review, facility policy ning seminar information, or Industry and FDA (Federal staff, dated 2006, view, the facility failed to be ner to ensure seven 18, #55, #94, #57, #83) enviornment of fourty-three he facility's fallure to essess for the use of eliminate full sideralls to duce the risk of entrapment #60, and #18 and any side rails, in Immediate Credible Allegation of 5, 2012. A revisit emented on March 5, nediate Jeopardy. 21 continues at a "E" level one than minimal harm).	{F 490}	(c) The resident's physical family member and/or resident were made aware of side assessments/restraint fire 2/6/12, obtaining new or needed by the Nursing Administration Team, the and/or resident provided consent for the use of side rail/restraint as indicated Ongoing communication discussed with families/regarding the use of side restraint upon admission assessment findings chanthe Admission Coordinate Charge Nurse or Nurse Administration Team. 3.(a) The Administrator and Director of Nursing receives service training on 2/7/12. 2/21/12, by the Regional Nonsultant. The in-service covered areas but not limit	sician, residents e rail ndings on rders as ne family d verbal de l. will be residents rails and and/or as ge, by or, ad ved in- & Nurse	DATE
2012, removed the Imm Non-compliance for F-2 citation (potential for mo The findings included: Validation of the Credible Compliance was accomprecord review, review of observation, and intention	priented on March 5, nediate Jeopardy. 21 continues at a "E" level pre than minimal harm). E Allegation of polished through-medical	s 2 0 c s	Director of Nursing receives or 2/7/12. Service training on 2/7/12. 2/21/12, by the Regional National Consultant. The in-service	ed in- & Nurse ed to: nent	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

STATEMEN	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (21) PROVIDENSUPPLIERICAN			OMB NO	M APPRO D. 0938-
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	SURVEY
		445457	B. WING		1	R
	PROVIDER OR SUPPLIER		 -		03/	12/2012
EAST T	ENNESSEE HEALTH	CARE]	TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES	10	MADISONVILLE, TN 37354		
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HODE	COMPLE DATE
(F 490)	Continued From pa	age 29				
	efficiently to attain	or maintain at the same	(F 490	plans, investigation of		
	THE PROPERTY OF THE PROPERTY O	I Montal and		occurrences (falls),		
	well-being of each	esident.		implementation of intervent	ione	1
				to reduce the occurrence of	WII S	
	This REQUIREMEN by:	IT is not met as evidenced		incidents, monitoring		
.]	Based on medical r	poord for a		effectiveness of intervention		×
			•	referring residents for assess	15,	
				by therapist for appropriate	ment	
10	observation, and inte	stair, dated 2006,	1	interventions, job responsibi		
	administered in a ma	anner to ensure seven		abuse protocol (list not all	lities,	
				inclusive: investigation, repo	. 1	
10	esidents reviewed	The ferriment of fourty-three		screening of employees,	rting,	
			İ	employee training of employees,	.	
þ	revent falls and to re	eliminate full sideralls to		employee training). The facil	ity	
P	laced residents #41	the risk of entrapment	1	reduction collection is		
	esident who used ful eopardy.	#60, and #18 and any I side ralls, in Immediate	i	reduction collaborative with (5-	
- 1	5 45		1	Source. The Administrator	1	
TI	ne facility provided a	Credible Allegation of	1	contacted the Q-Source	1	
00	ompliance on March	5, 2012. A revisit		representative who registered	the	
CO	rrective actions imp	2, 2012, revealed the		Director of Nursing, Assistant		
20	12, removed the importance for E	mediate Jeonardy	1	Director of Nursing, Activity		
cit	in-compliance for F-	221 continues at a "E" level		Director and MDS Coordinato	r j	
1		ore than minimal harm).	İ	for a Physical Restraint &		
Th	e findings included:		1	Pressure Ulcer Regional		
Val	idation of the Credit	No Alta di		Collaborative Learning Sessio	n	(**)
	mpliance-was-accon	ne Allegation of hplished-through-medical		on April10, 2012.	1.	
obs	ord review, review o	f facility policy,	\rightarrow	(b) The Regional Director of		
		ew with the nurses,	1	Operations in-serviced the		
2050200	and	administrative staff. The	1	Administrator the No.		
>-2067(02-	99) Previous Versions Obsol	ote Event ID: 9D8D12		Administrator, the Maintenance		

Notes :

	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDE HISUPPLIERICLIA	(X2) M(F)	TIPLE CONSTRUCTION	OMB NO	M APPRON 0. 0938-0
		IDENTIFICATION NUMBER:	A. BUILDI	(X3) DATE COMPL		
		445457	B. WING	R		
	PROVIDER OR SUPPLIER		Te-		03/	12/2012
EAST TE	NNESSEE HEALTH	CARE	1 4	REET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	MADISONVILLE, TN 37354		
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III O DE	(X5) COMPLET DATE
(F 490)	Continued From pa	ige 29				
	efficiently to attain a	or maintain the test	{F 490}	Director and the Maintenance	ė	1
1	Franchick Dilvsich	mental and never	8	Assistant regarding the FDA	_	ł
ĺ	well-being of each r	esident		Safety Alert: Entrapment Haz	zarde	
	This Beauty		-	with Hospital Bed Side Rails	and	
	this REQUIREMEN	IT is not met as evidenced		shared by the surveyors durin	o.	
	Based on medical r	ecord review, facility policy		facility demonstration of	5	į.
			. [measuring bed zones (include	a	
1	Orug Administration	etaff detail and FDA (Federal		flat and articulated positions)	OP.	
				2/7/12. The Maintenance		
n	esidents (#A1 #GD	anner to ensure seven	11	Director and the Maintenance	- 1	
M	vere provided a safe	#18, #55, #94, #57, #83) enviornment of fourty-three	11	Assistant were able to	i	
l re	esidents reviewed.	The facility's failure to	/1	demonstrate competency throu	ıch	
si	derails, to reduce of	issess for the use of	11	a return demonstration on 2/7/	12	
p	event falls and to re	duce the risk of entrapment		on measuring the bed zones in	flot	*
re	sident who was full	#80, and #18 and any	11.	and articulated positions (relate	Alat	
Je	opardy,	#60, and #18 and any I side rails, in Immediate		to the information provided	a	
TH	o facility const	_	1	during the survey). The Region	o1	
Co	empliance on March a lactility provided a	Credible Allegation of	1	Director of Operations also in-	aı	
00	nducted on March	0, 2012. A revisit	s	serviced the Maintenance Direc	to-	
20	12. removed the	2, 2012, revealed the emented on March 5,	a	and Assistant on 2/13/12	101	
No	n-compliance for E	neulate Jeopardy.	n	egarding The FDA Hospital Be	ا و	
Olte	ition (potential for m	ore than minimal harm).	S	ystem Dimensional and	au	
The	findings included:		A	assessment Guidance to Reduce		
1			E	ntrapment dated March 10,	,	
Con	dation of the Credib	le Allegation of	20	006.	1	
reco	ord review review	nplished-through-medical-				
obse	ervation and interes	racility policy,	(0) The Administration Team		
nurs	ing assistants, and	ew with the nurses, administrative staff. The	(A	dministrator, Director of		
	9) Previous Versions Obsole	- ran, me	N	ursing, and Assistant Director of	1	

Validation of the Credible Allegation of Gompliance-was accomplished through medicalrecord review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The

(d) The Administrator and Director of Nursing will review patient information with the interdisciplinary team in the morning QA meeting, disbursing

ORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN6201

Event ID: 9D8D12

NAJRI DI	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3)	MULT	TIPLE CONSTRUCTION	(X3) DATE	0.0938-0 SURVEY
		The state of the s	A, BI	JILOII	NG	COMP	
ANAE OF		445457	B, W	ING_			R
	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	03/	12/2012
AST TE	ENNESSEE HEALTH	CARE		1 4	165 ISBILL RD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		N	MADISONVILLE, TN 37354		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LUDBE	COMPLET DATE
The Control of the Co	efficiently to attain a practicable physical well-being of each by: This REQUIREMENT by: Based on medical review, review of trainerview of Guidance Drug Administration observation, and integration and integration of the credit of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the credit of the control of the credit of the control of the credit of the control of the credit of the c	or maintain the highest al, mental, and psychosocial resident. AT is not met as evidenced record review, facility policy sining seminar information, for Industry and FDA (Federal) staff, dated 2006, erview, the facility failed to be anner to ensure seven #18, #55, #94, #57, #83) environment of fourty-three The facility's failure to assess for the use of a reliminate full siderails to educe the risk of entrapment and #18 and any and #18 and any and #18 and any are side rails, in Immediate a Credible Allegation of a 5, 2012. A revisit 12, 2012, revealed the allemented on March 5, amediate Jeopardy. "221 continues at a "E" level force than minimal harm).	{F 4		information to appropriate caregivers, residents, and/or family members to obtain the residents highest physical functioning and psychosocial needs. The Administration to will consult with the Medical Director as needed for guidar delivering patient care and the revision of policy and proced. 4. (a) The Administrator or Director of Nursing will conduct random audits weekly through facility walking rounds, review the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use Side Rails, and Nurse Event not one ensure the appropriate procedures and policies are befollowed. The Administrator of report findings in the morning Quality Assurance Meeting (Monday-Friday) and review withe Medical Director in the quarterly QA meeting and as	e e e e e e e e e e e e e e e e e e e	
rec obs nur	ord review, review of	npilshed through medical- of facility policy, iew with the nurses, administrative staff. The		-	nceded. (b) The Regional Nurse Consultant will conduct random audits of facility documentation	1	·—

DEPARTMENT OF HEALTH AND HOMAN MEDICALLY

s in the page of

CENT	CEDO E OF MILATIN	CAMP FERRING PLACE CONT.			1 (5.5%), (0. 03/14/2 ₀
CEN	ERS FOR MEDICARI	& MEDICAID SERVICES			FORI OMB NO	4 APPROVE 0. 0938-039
AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER	(YP) MULD	TIPLE CONCERUCTION	(X3) DATE	SURVEY
		445457	B. WING			R
NAME O	F PROVIDER OR SUPPLIER	-				12/2012
EAST	TENNESSEE HEALTH		2.	TREGT ADDRESS, CITY, STATE, ZIP C 465 ISBILL RD MADISONVILLE, TN 37354	ODE	
(X4) IC PREFIX TAG	V I WACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETION DATE
	facility developed a with the involvement include the utilization of side rails. The faside rail assessment removal of side rails evidence bed zone into reduce or eliminal facility provided evidence and random audits to the facility provided evidence and random audits to the facility will remain level until it provides correction to include ensure the deficient of the facility's corrective reviewed and evaluate Committee. 483.75(i) RESPONSIIDIRECTOR The facility must design as medical director. The medical director is implementation of resist coordination of medical this REQUIREMENT by:	Side Rail Assessment Policy of the Medical Director to not the evaluation for the use cility provided evidence of the evaluation for the use cility provided evidence of the evaluation for the use cility provided evidence of the evaluation and residents, and when indicated, and when indicated, and measurements were obtained the entrapment risk. The ence Fall Risk Assessments, sments, and Physical nats were completed. The ence of in-service for all staff or ensure compliance at a "E" an acceptable plan of continued monitoring to practice does not recur and expenditude the end by the Quality Assurance and by the Quality Assurance of the Elicate and the end of the en	{F 490}	1.43	aff acility is ce with eral ctor of ct random ensure the ed e, and ctions and trions and trychosocial	
1.0	eview, observation and Director failed to provide	ord-review, facility-policy—d interview the Medical				

Director failed to provide oversight and participate in the development of policies and procedures to

DEPARTMENT OF HEALTH AND HUMAN SHAVICES.

	LD.	Water	
FC	PM A	APPIN	PYCE

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO.	0938-031
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		44545 7 ^R	B, WING			₹ 2/2012
	PROVIDER OR SUPPLIER ENNESSEE HEALTH	CARE	s	TREET ADDRESS, CITY, STATE, 2IP COD 465 ISBILL RD MADISONVILLE, TN 37354	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
{F 490}	facility developed a with the involveme include the utilization of side rails. The facility assessme removal of side rail evidence bed zone to reduce or eliminate facility provided evidence Restraint Assessme facility provided evidence to reduce or eliminate facility provided evidence facility provided evidence facility provided evidence facility provided evidence involved evidence facility provided evidence involved evidence facility provided evidence involved evidence facility provided evidence facil	age 30 a Side Rail Assessment Policy at of the Medical Director to on of the evaluation for the use acility provided evidence of ants for all residents, and as when indicated, and measurements were obtained ate entrapment risk. The adence Fall Risk Assessments, assments, and Physical ents were completed. The dence of in-service for all staff to ensure compliance.	{F 490			
{F 501} SS=E	level until it provide correction to include ensure the deficien the facility's correct reviewed and evalue Committee. 483.75(i) RESPONS DIRECTOR	ain out of compliance at a "E" s an acceptable plan of e continued monitoring to t practice does not recur and ive measure could be ated by the Quality Assurance SIBILITIES OF MEDICAL	{F 501}	100 50.5		
	as medical director.			483.75(i) Responsible of M Director	edical	
	The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.			SS=E Requirement:		
	by:	T is not met as evidenced		The facility must designate a physician to serve as medical		
	review, observation	and interview the Medical vide oversight and participate		director. The medical director responsible for implementation	r is on of	e de la companya de l

in the development of policies and procedures to

resident care policies; and the

DEPARTMENT OF HEALTH AND HUMAN LEFT VIOLS.

FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIF R/CLIA IDENTIFICATION NUMBER:	(X2) MUI_7 A. BUILDI	TIPLE CONSTRUCTION.	(X3) DATE SURVEY COMPLETED R 03/12/2012	
4000		445457	B. WING_			
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
EAST TE	ENNESSEE HEALTH	CARE		465 ISBILL RD MADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
{F 501}	ensure resident sat with restraints were	fety and ensure that residents properly assessed, managed, tion or elimination was	{F 501}	coordination of medical care in facility. Corrective Action Plan:	1 the	
(41)	Compliance on Marc conducted on Marc corrective actions in 2012, removed the Non-compliance for	d a Credible Allegation of rch 5, 2012. A revisit h 12, 2012, revealed the mplemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level r more than minimal harm).		1. The facility's Medical Dirwas made aware by the Administrator on 2/8/12 that facility had received immedi jeopardy level deficiencies	the	
	Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.			including F 490 for the many which the facility has been administrated. The Quality Assurance Committee met we the Medical Director on 2/23 to review deficiencies sited of the facility's recent annual sur The Administrator reviewed a literature on The Food and Dradministration Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. During the meeting with the Medical Director, the Administrator also reviewed to	ith /12 uring urvey. the rug uce	
["	correction to include	n-out of compliance at a "E" an acceptable plan of continued monitoring to practice does not recur and		role of the Medical Director at the Quality Assurance process	nd	as š

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:908012

Facility ID: TN6201

THE PARTMENT OF BLACTH AND BUMAN SERVICES

CHANTLES GESTARES FORM APPROVE

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) {F 501} Continued From page 31 {F 501} assisting the facility with ensure resident safety and ensure that residents identifying problems, evaluating, with restraints were properly assessed, managed. and restraint reduction or elimination was and addressing concerns to implemented where appropriate. improve resident outcome The facility provided a Credible Allegation of through the development and Compliance on March 5, 2012. A revisit revision of policy and procedures conducted on March 12, 2012, revealed the as needed. corrective actions implemented on March 5. 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level 2. The Nursing Administration citation (potential for more than minimal harm). Staff (Director of Nursing, Staffing Coordinator, and MDS The findings included: Coordinator) reviewed all Validation of the Credible Allegation of residents using side rails, Compliance was accomplished through medical assessing and coding the record review, review of facility policy, resident's assessment correctly. observation, and interview with the nurses, Residents using side rails as a nursing assistants, and administrative staff. facility developed a Side Rail Assessment Policy restraint were identified and care with the involvement of the Medical Director to planned accordingly. A include the utilization of the evaluation for the use comprehensive assessment was of side rails. The facility provided evidence of completed; interventions were side rail assessments for all residents, and modified as needed and placed on removal of side rails when indicated, and evidence bed zone measurements were obtained the individuals care plan. The to reduce or eliminate entrapment risk. The Administration Team facility provided evidence Fall Risk Assessments, (Administrator, Director of Pre-Restraint Assessments and Physical Nursing, and Assistant Director of Restraint Assessments were completed. The facility provided evidence of in-service for all staff Nursing, MDS Coordinator, and random audits to ensure compliance. Maintenance Supervisor, Social Services Director, Activity The facility will remain out of compliance at a "E" Director, Food Service level until it provides an acceptable plan of Supervisor, Bookkeeper, Therapy correction to include continued monitoring to ensure the deficient practice does not recur and Team Leader/Therapy Program

FORM CMS-2567(02-99) Provious Versions Obsolete

Event (D:9D8D12

Facility ID: TN6201

Positivit La DEPART (1) FORM APPROVE OMB NO. 0938-039

MAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TASK) FREETY TASK CASI ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TASK) TASK CONTINUED FROM page 31 characteristic strip and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the unsvess, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment with Medical Director or 2/23/12. The Administrator reviewed the functions and responsibilities with Medical Director or 2/23/12. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff. 1 (a) The Administrator will review the functions of the Medical Director to include the utilization of the evaluation for the use of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of all Risk Assessments, Pre-Restraint Assessments were completed. The facility provided evidence of facility policy of the facility provided evidence of marvice of the facility provided evidence of marvice of the facility provided evidence of marvice of the facility provided evidence of marvice of the facility provided evidence of marvice of the facility provided evidence of marvice of the fa		OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		G	COMPL	LETED
EAST TENNESSEE HEALTH CARE EAST TENNESSEE HEALTH CARE SUMMADISONVILLE, TN 37354 SUMMADISONVILLE, TN 37354 SUMMADISONVILLE, TN 37354 REGULATORY OR LSC DENTIFYING INFORMATION) (F 501) Continued From page 31 ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit Conducted on March 5, 2012. A revisit Conducted on March 5, 2012. A revisit Conducted on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions implemented on March 5, 2012, revealed the corrective actions from the Immediate Jeopardy, Non-compliance for F-221 conflues at a "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director of Nursing will notify the Medical Director of include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rails assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restarint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility will remain-out	İ		445457	B. WIN	IĢ		03/	R 12/2012
(F 501) Continued From page 31 ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, rewealed the corrective actions implemented on March 5, 2012. A revisit conducted on March 12, 2012, rewealed the corrective actions implemented on March 5, 2012. A revisit conducted on March 12, 2012, rewealed the corrective actions implemented on March 5, 2012. The Administrator reviewed the functions and responsibilities with Medical Director on 2/23/12. The Administrator and/or Director of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director of Nursing will notify the Medical Director of include the utilization of the evaluation for the use of side rails. The facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director of Nursing will notify the Medical Director of Nursing will notify the Medical Director of development of policies and procedures to meet the needs of resident and/or staff. 4. (a) The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed.	EAST TE	NNESSEE HEALTH (TEMENT OF DEFICIENCIES		46 M	65 ISBILL RD IADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECT	TION	
ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were properly assessed, managed, and restraints were possible and revisite minuted and procedure and procedure and the Medical Director of the Medical Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff. 4. (a) The Administrator will review the functions of the Medical Director to resident and/or staff. 4. (a) The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed.		REGULATORY OR L	SCIDENTIFYING INFORMATION)		<u> </u>	CROSS-REFERENCED TO THE APPR	ROPRIATE	DATE
· · · · · · · · · · · · · · · · · · ·	to see the first and the contract of the contr	ensure resident saft with restraints were and restraint reduct implemented where and restraint reduct implemented where The facility provided Compliance on Marci corrective actions in 2012, removed the Non-compliance for citation (potential for The findings include Validation of the Cre Compliance was accrecord review, review observation, and intenursing assistants, a facility developed a Swith the involvement include the utilization of side rail assessment removal of side rails evidence bed zone more reduce or eliminate acility provided evide or eliminate acility provided evidence random audits to the facility will-remain evel until it provides a correction to include or rection to include or rection to include of the facility will-remain evel until it provides a correction to include or rection to include of the facility will-remain evel until it provides a correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to include the correction to the correction t	ety and ensure that residents properly assessed, managed, ion or elimination was appropriate. If a Credible Allegation of the 5, 2012. A revisit in 12, 2012, revealed the inplemented on March 5, Immediate Jeopardy. F-221 continues at a "E" level in more than minimal harm). In the individual of the individual indivi	{F 50	01}	Director) developed a Side Policy with the involvement the Medical Director with implementation on 2/28/12 include the utilization of the Evaluation for the use of Side Rail Assessment. 3. The Administrator review functions and responsibilities Medical Director on 2/23/12 Administrator and/or Direct Nursing will notify the Medical Director as needed regarding that requires the revision and development of policies and procedures to meet the needs resident and/or staff. 4. (a) The Administrator will the functions of the Medical through random audits and enthat the development/revision policies or systems is completed the quarterly QA meeting and needed. (b) The Administrator and	tof to ede de ved the es with 2. The or of ical gissues l/or of review Director usure n of eted in d as	
						Discost of fraising will fevie	sw :	

THE LABORAGE ME OF BEALTH AND AUGUSTANAS SEE VIOLES.

radio M.L. Obrasi et

CLNTE	RS FOR MEDICAR	E & MEDICAID SERVICES				. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OUA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445457	B, WING		03/	R 1 2/2012
EAST TE	PROVIDER OR SUPPLIER	CARE .	S	TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354	037	1212012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFIGIENCY)	NULD BE	COMPLETION DATE
i de de de de de de de de de de de de de	ensure resident sa with restraints were and restraint reduce implemented when The facility provide Compliance on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted on Marconducted the Non-compliance for citation (potential for The findings include Validation of the Crompliance was acrecord review, review observation, and into hoursing assistants, a facility developed a with the involvement of side rails assessment of side rail assessment endicted the utilization of side rail assessment or reduce or eliminate acility provided evidence bed zone response to reduce or eliminate acility provided evidence facility provided evidend random audits to the facility-will-remail	fety and ensure that residents a properly assessed, managed, fion or elimination was a appropriate. d a Credible Allegation of rch 5, 2012. A revisit th 12, 2012, revealed the implemented on March 5, Immediate Jeopardy. r F-221 continues at a "E" level or more than minimal harm). ed: edible Allegation of complished through medical with the nurses, and administrative staff. The Side Rail Assessment Policy to the Medical Director to in of the evaluation for the use cility provided evidence of its for all residents, and when indicated, and measurements were obtained the entrapment risk. The ence Fall Risk Assessments, sments and Physical ints were completed. The ence of in-service for all staff of ensure compliance.	{F 501	patient information with the interdisciplinary team in the morning QA meeting, disbur information to appropriate caregivers, residents, and/or family members to obtain the residents highest physical functioning and psychosocial needs. The Administrator and Director of Nursing will notif the Medical Director as needs regarding issues that requires revision and/or development policies and procedures to me the needs of resident and/or st	rsing e d/or fy ed the of	
a c	orrection to include	an acceptable plan of continued monitoring to practice does not recur and				

FRINTED: 03/14/2012 FORM APPROVED

EAST TN HEALTH CARE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 03/12/2012 445457

NAME OF PROVIDER OR SUPPLIER

EAST TENNESSEE HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD

EAST IE	NNESSEE HEALTH CARE	IVI	MADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
{F 501}	the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee.	{F 501}				
(F 502) SS≃D	483,75(j)(1) ADMINISTRATION	{F 502}	F 502	8		
33-D	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	**	483.75 (j)(1) Administration			
	of the services.	88	SS=D			
	This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory tests timely for three residents (#7, #41, and #60) of forty three residents reviewed. The findings included: Resident #7 was admitted to the facility on January 5, 2012, with diagnoses including Dementia with Depression, Atrial Fibrillation, and Anxiety. Medical record review of the Interdisciplinary Plan of Care dated January 17, 2012, revealed "risk for fallsrisk for bleeding R/T (related to) anticoagulant uselabs as ordered"		Requirement: The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Corrective Action Plan: 1. (a) Resident #7 had a PT/INR completed on 2/14/12 by the charge nurse with findings reported to the physician.			
	Medical record review of the Physician Admission Orders dated January 5, 2012, revealed "repeat PT/INR (Prothrombin Time/International Ratio-lab test that measures blood clotting) next PT/INR due 2-5-12"		(b) As of 2/21/12 resident #41 has had PT/INR labs completed as ordered. (c) As of 2/21/12 resident #60 has			
	Medical record of a Physician's Telephone order dated January 12, 2012, revealed "Repeat		had PT/INR labs completed as ordered.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FIGNIED: 05/14/2012 FORM APPROVED

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OWR NO	0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S	ETED
		445457	8, WING		1	R 1 2/2012
	PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354		del de v. see
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	PT/INR 2-3-12 DC 2-5-12" Medical record reviper order dated February 14, 2012, 1.7" Interview with Direct February 13, 2012, residents PT/INR with facility failed to concluding Alzheimer Thrombosis and Hyll Medical record reviee Order dated January "Continue Coumact (every day) at 1600 (measures blood clo 16, 2012)" Review of the medical laboratory results for 2012	riew of the chart revealed no February 3, 3012. riew of a Physician's Telephone ary 12, 2012, revealed "Draw revealed "Draw revealed "Draw revealed "PT 17.0INR ctor of Nursing (DON) on at 4:00 p.m., confirmed the read the revealed representation of the laboratory test. admitted to the facility on 1, and readmitted to the 24, 2012, with diagnoses repertension. ew of a Physician's Telephone by 2, 2012, revealed din (anticoagulant) 10 mg qd (4:00 p.m.) repeat PT/INR of thing)in 2 weeks (January chair record revealed no retring of the pertension	{F 502	2. The DON audited the labs patients receiving Coumadin 3/16/12 with no findings of n PT/INR results. 3. Licensed nurses were in-se on 2/17/12, 2/29/12, and 3/15 the process for obtaining labs ordered. 4. The Director of Nursing or designee will conduct random audits weekly to ensure that P labs are completed as ordered (6) weeks. Findings will be re in the morning QA meeting. Completion date: 3/22/12	on nissing erviced 5/12 on as a chart T/INR	
ļ f	Medical record review Flowsheet dated Jan	w of the Coumadin				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9D8D12

Facility ID: TN6201

PAGE 99/99

PENNYED: 03/14/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION .. (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B. WING 03/12/2012 445457 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 465 ISBILL RD EAST TENNESSEE HEALTH CARE MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PRÉFIX PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG {F 502} {F 502} Continued From page 34 "...1-19-2012...Lab result INR 2.1..." Interview with the Director of Nursing on February 14, 2012, at 11:10 a.m., in the Nurse's Station, confirmed the facility failed to ensure the laboratory test was done timely. Resident #60 was readmitted to the facility on September 26, 2011, with diagnoses including Pneumonia with Aspiration, Alzheimer's Disease, Congestive Heart Failure, Weakness, and GERD (Gastroesophageal Reflux Disease). Medical record review of a Physician's Telephone Order dated December 2, 2011, revealed "...recheck PT/INR (measures blood clotting) in 1 week 12-16-11..." Medical record review revealed no PT/INR was completed on December 16, 2012. Medical record review of the Coumadin Flowsheet dated December 2011, revealed "...12-19-2011...Lab result INR 2.1..." Interview with the Director of Nursing on February 14, 2012, at 11:10 a.m., in the Nurse's Station, confirmed the facility failed to ensure the laboratory test was done timely. F520 (F 520) 483.75(o)(1) QAA {F 520}

FORM CMS-2567(02-99) Previous Versions Obsolete

SS=E

COMMITTEE-MEMBERS/MEET

A facility-must-maintain-a-quality-assessment-and-

assurance committee consisting of the director of nursing services; a physician designated by the

facility; and at least 3 other members of the

QUARTERLY/PLANS

Event ID:9D8D12

Facility ID: TN6201

SS=E

Requirement:

483.75 (O)(1) QAA Committee-

Members/Meet Quarterly/Plans

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		445457	B. WIN	√G_		03/12	2/2012
EAST TE	ROVIDER OR SUPPLIER NNESSEE HEALTH (CARE	ID	4	REET ADDRESS, CITY, STATE, ZIP CODE 65 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORREC	ETION	(%5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	COMPLETION
	committee meets a issues with respect and assurance action develops and imple action to correct ide. A State or the Sec disclosure of the reexcept insofar as a compliance of such requirements of this. Good faith attempts and correct quality a basis for sanction. This REQUIREMENT by: Based on medical facility policy review failed to ensure the developed and implication and the safety relatively entrapment and (#41, #18, #60) of The facility's failure and #60, and any rein Immediate Jeopa provider's noncomprequirements of par	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies. retary may not require cords of such committee uch disclosure is related to the e committee with the e section. by the committee to identify deficiencies will not be used as	{F 5	20}	A facility must maintain a quassessment and assurance conconsisting of the director of reservices; a physician designathe facility; and at least 3 oth members of the facility's start quality assessment and assurance committee meets at least qualidentify issues with respect to quality assessment and assurance vivities are necessary; and and implements appropriate action to correct identified qualiciencies. Corrective Action Plan: 1. A special session of the Assurance QA Committee (Administrator, Director of Nursing, and Assistant Dir Nursing, MDS Coordinato Maintenance Supervisor, Services Director, Activity Director, Food Service Supervisor, Bookkeeper, Team Leader/Therapy Promanager, and/or Medical Director) was held on 2/23 the Administrator. The	mmittee nursing ted by er eff. The ance rterly to o which ance develops plans of nality Quality f ector of r, focial herapy gram	
	The facility provided	l a Credible Allegation of		e e	committee reviewed the re	sults of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		¥	(X3) DATE SURVEY COMPLETED	
		AAF4FT	B, WIN			F	
NAME OF S	POWDED OF THEFT	445457				03/12	/2012
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
EAST TE	NNESSEE HEALTH C	CARE			AADISONVILLE, TN 37354		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 520}	Continued From pa	an ôt	-		ine annual survey as expres	sed	
(1 020)	facility's staff.	ge 35	{F 5	20}	during are survey exit with	DUTE AND SET	
	idolity & Stall.				review of the immediate spe	ecifics	1
	The quality assessr	nent and assurance			and implementation of the p	lan of	
committee meets at		t least quarterly to identify			correction to remove the		
	issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.				immediate jeopardy. A Side	Rail	
					Policy was developed by the		
					Committee and the Medical		
	A State or the Secr	etary may not require		23	Director with implementation	n on	
disclosure of the records of such commexcept insofar as such disclosure is relacompliance of such committee with the requirements of this section.	disclosure of the red	cords of such committee		100	2/28/12 for the assessment of		
	ich disclosure is related to the		125	residents for the use of side	100 C C C C C C C C C C C C C C C C C C		
	requirements of this	section,			the review of MDS's and Ca		
	Ca-d fa'll - 11 - 1		-		Plans to ensure current		
Ì	and correct quality of	by the committee to identify deficiencies will not be used as			interventions and accuracy;	he	
	a basis for sanctions	s.			review of Occurrences/Even		
					Falls (including, but not limi		
	This REQUIREMEN	IT is not met as evidenced			Evaluation for the use of Sid		
	by:				Rails, Pre-Restraint, Physical		
	Based on medical r	ecord review, observation,	* 9				
	failed to ensure the	and interview, the facility Quality Assurance Committee			Restraint Assessment, Care F	105	
	developed and imple	emented plans to address		}	Nurse Aide Communication	on,	
- 1	resident safety relate	ed to the use of full side rails			Nurse Aide Communication	•	
	(#41, #18, #60) of fi	d fallsfor three residents orty-three residents reviewed.			Sheet, Root Cause Analysis f	or	
T	The facility's failure	placed resident's #41, #18			appropriate Interventions		
	and #60, and any re-	sident who used full side rails		-	including the FROG Program	,	
	provider's noncompl	rdy (situation in which a iance with one or more			and telephone orders); the		
- 1	requirements of part	icipation has caused or is	**		monitoring by the Administra	tive	
	likely to cause seriou death).	us harm, injury, impairment or		-	staff to ensure systems are		
	ucall).				followed and revised as neede	ed;	
1	The facility provided a Credible Allegation of			- 1	and to ensure staff training is		
		1077			provided as needed for	<u></u>	
JKM CM\$-256	7(02-99) Previous Versions (Obsolcte Event ID:908D12		Fac	lity ID: TN9201 If contin	uation sheet I	Page 36 of 38

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: CS/14/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445457	B. WING	-	R 03/12/2012	
	PROVIDER OR SUPPLIER ENNESSEE HEALTH OF SUMMARY STA	CARE	S	TREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354 PROVIDER'S PLAN OF CORRE		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	DATE I	
{F 520}	facility's staff. The quality assess committee meets a issues with respect and assurance acti develops and imple action to correct ide. A State or the Sec disclosure of the reexcept insofar as a compliance of such requirements of this. Good faith attempts and correct quality a basis for sanction. This REQUIREMENT by: Based on medical facility policy review failed to ensure the developed and implements and implement and implements affety relailikely entrapment and (#41, #18, #60) of the facility's failure and #60, and any rein Immediate Jeopa provider's noncomprequirements of partikely to cause serio death).	ment and assurance It least quarterly to identify It to which quality assessment Vities are necessary; and Imments appropriate plans of Entified quality deficiencies. Interest may not require Cords of such committee Uch disclosure is related to the It committee with the Its section. It is by the committee to identify It is deficiencies will not be used as	{F 520	processes/systems implementate of the Plans, Occurrences discussing and modifying as needed to maintain compliance. 2. The Nursing Administration as a restraint were idea and care planned according comprehensive assessment completed; interventions we modified as needed and plate individuals care plan. Administration Team deverside Rail Policy with the involvement of the Medica Director with implementate 2/28/12 to include the utility of the Evaluation for the utility of the Ev	eview annual ve: ment, re- ysical DS's, systems tion susing ding side ntified gly. A was vere aced on The cloped a al tion on ization	
DRM CMS-25	67(02-99) Previous Versions			Side Rail Assessment.		
		Obsoleto Event (D:9D8D12	F	acilit INDZUI If con	atinuation cheet Page 36 of 3	

PAGE 99/99

PRINTED: 09/14/2000

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391 V3 DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION . A. BUILDING			COMPLE	TED
		445457	B. WIN	NG_		03/12	2/2012
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	(X5) COMPLETION DATE
{F 520}	facility's staff. The quality assess committee meets a issues with respect and assurance actidevelops and impleaction to correct ide. A State or the Sec disclosure of the reexcept insofar as a compliance of such requirements of this Good faith attempts.	ment and assurance at least quarterly to identify to which quality assessment wities are necessary; and ements appropriate plans of entified quality deficiencies. retary may not require ecords of such committee uch disclosure is related to the a committee with the s section. s by the committee to identify deficiencies will not be used as	{F 5	20}	3. The QA Committee receinservice training by the Administrator and the Reg Nurse Consultant on 2/21/2/22/12, and 2/23/12. The service covered but was not limited to: facility QA Poland Procedures; Daily QA morning meetings; Month (Leadership team, Custom Service, Patient Care and Service); and Quarterly Q setting, brainstorming, rocanalysis, etc.) The QA Cowill address concerns idea during the above meeting	tional 12, tin- ot ticies ly QA ner A (goal ot cause ommittee ntified s as	
	by: Based on medical facility policy review failed to ensure the developed and impresident safety relatively entrapment at (#41, #18, #60) of The facility's failure and #60, and any rein Immediate Jeopa provider's noncomprequirements of par Jikely to cause serio death).	record review, observation, and interview, the facility Quality Assurance Committee lemented plans to address ted to the use of full side rails and fallsfor three residents forty-three residents reviewed. placed resident's #41, #18, esident who used full side rails ardy (situation in which a pliance with one or more rticipation has caused or is bus harm, injury, impairment or			needed, implementing gu modifications with the as of the Medical Director to reduce or eliminate conce identified. The team wil alerts from agencies such not limited to: Center for Medicare Services, Tenn Health Care Association, Source to ensure approprimeasures are taken to ob goals associated with age recommendations. Infor	idelines, sistance oresolve erns 1 review as, but ressee, and Q-riate tain the ency	mana iy .
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 9D8D12		Fac	Ally ID: TN6201 If cont	inuation sheet	Page 36 of 38

DEPARTMENT OF BEAUTH AND HUMAN SURVICES PRINTED: 03/14/201 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVEL OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED R B. WING 445457 03/12/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY {F 520} Continued From page 35 discussed in the QA Committee {F 520} facility's staff. will be disbursed to appropriate department personnel to improve The quality assessment and assurance committee meets at least quarterly to identify patient care and services by a QA issues with respect to which quality assessment representative through training and assurance activities are necessary, and develops and implements appropriate plans of and educational sessions. action to correct identified quality deficiencies. 4. The Administrator or Director of A State or the Secretary may not require Nursing will review facility audits in disclosure of the records of such committee except insofar as such disclosure is related to the morning QA meetings (Mondaycompliance of such committee with the Friday) and in the quarterly QA requirements of this section. meeting to review areas that have Good faith attempts by the committee to identify improved and/or may need revisions. and correct quality deficiencies will not be used as Action plans will be developed when a basis for sanctions. a practice is determined to be deficient; the committee will monitor This REQUIREMENT is not met as evidenced until compliance is met. by: Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee For Clarification Purposes: The developed and implemented plans to address resident safety related to the use of full side rails OA Committee consists of Medical likely entrapment and fallsfor three residents Director, Administrator, Director of (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, Nursing, Assistant Director of and #60, and any resident who used full side rails Nursing, MDS Coordinator(s), in Immediate Jeopardy (situation in which a provider's noncompliance with one or more Bookkeeper, Food Service requirements of participation has caused or is Supervisor, Social Worker, likely to cause serious harm, injury, impairment or-Maintenance Director and/or death). Maintenance Assistant, Activities The facility provided a Credible Allegation of

FORM CMS-2567(02-99) Previous Versions Obsoleto

Event ID:9D8D12

Facility ID: 1N6201

Director. Direct caregivers (list not

ORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTLE, 65/14/PGA CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938 0301 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 445457 NAME OF PROVIDER OR SUPPLIER 03/12/2012 STREET ADDRESS, CITY, STATE, ZIP CODE EAST TENNESSEE HEALTH CARE 465 ISBILL RD MADISONVILLE, TN 37354 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X6) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 520} all inclusive: Licensed Nurses, Continued From page 35 {F 520} facility's staff. CNA's, Restorative, Therapy) may be in attendance. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment Completion Date 3/22/12 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of

Event ID:9D8D12

Facility ID: 7'N6201

PAGE 99/99

DEFARTMENT OF HEALTH AND RUMAN SERVICES

13.17511.05/04/51/9 FORM APPROVED
OMB NO 0938-0391

CENTER	(S FOR MEDICARE	& MEDICAID SERVICES					. 0930-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION, A BUILDING			COMPL	(X3) DATE SURVEY COMPLETED	
		B. W	NG			R 2/2012		
	ROVIDER OR SUPPLIER NNESSEE HEALTH	CARE		46	EET AODRESS, CITY, STATE, Z 5 ISBILL RD ADISONVILLE, TN 37354			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		CTION SHOULD BE THE APPROPRIATE	COMPLETION DATE		
{F 520}	conducted on Mar corrective actions 2012, removed the Non-compliance for citation (potential of The findings included)	erch 5, 2012. A revisit ch 12, 2012, revealed the implemented on March 5, implemented by March 5, implemented Jeopardy. F-221 continues at a "E" level for more than minimal harm).	{F !	520}		•		
	Compliance was a record review, reviobservation, and in nursing assistants facility developed with the involvement include the utilization of side rails. The side rail assessment removal of side rail evidence bed zone to reduce or elimin facility provided evidence bed zone to reduce or elimin facility provided evidence bed zone to reduce or elimin facility provided evidence bed zone to reduce or elimin facility provided evidence and random audits facility conducted a Assurance comming review the Side Rail assessment of all rails, the review of Plans to ensure cuaccuracy; the monstaff to ensure system needed; and to	redible Allegation of accomplished through medical lew of facility policy, and administrative staff. The a Side Rail Assessment Policy and of the Medical Director to on of the evaluation for the use facility provided evidence of ants for all residents, and all swhen indicated, and a measurements were obtained atteentrapment risk. The action of a measurements were obtained atteentrapment risk. The action of a measurements were obtained atteen and Physical ments were completed. The action of in-service for all staff as to ensure compliance. The action of the Quality are action of the Quality and Assessment Policy for the residents for the use of side Minimum Data Sets and Care are interventions and actioning by the Administrative tems are followed and revised ensure staff training is d for processes/systems	i i					

EAST TN HEALTH CARE

FAGE	22/	22
i.CH.Pr	03/34	10

14.174-1	Ten the OF 18,73 Th	(AMERICAN PERMITS				OMB NO	. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X4) PROVIDE RESUMENCIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 03/12/2012			
445457			B, WIN	IG				
NAME OF PROVIDER OR SUPPLIER EAST TENNESSEE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 465 ISBILL RD MADISONVILLE, TN 37354					
(X4) ID PREFIX TAG	reach deficienc	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
{F 520}	Continued From pa	age 37	{F 5	20}	6 00			
	level until it provide correction to include ensure the deficier the facility's correct	nain out of compliance at a "E" es an acceptable plan of le continued monitoring to at practice does not recur and tive measure could be uated by the Quality Assurance			· · · · · · · · · · · · · · · · · · ·	5 .		
(2)					8			
				B				
e.	i e				a .	1 .		

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 9D8D12

Facility ID: TN6201